OhioHealth

Equal Opportunity Employer

OhioHealth GME Application to Training Program

Applicant Information

First Name _____ **Preferred Name** _____

Middle Name _____ **Cell Phone** _____

Last Name _____ **Different Name** _____

Credentials _____ **Email** _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Program applying to Select from dropdown

Academic year applying for _____

Education and Match Information

Undergraduate: Institution _____

Degree _____ Graduation Date _____

Medical School: Institution _____

Degree _____ Graduation Date _____

Residency: Institution _____

Specialty _____ ACGME Accredited? Yes ☐ No ☐

Start date _____ Graduation Date _____

Program Director _____ Program Director Phone _____

Program Director Email _____

Residency/Fellowship: Institution _____

Specialty _____ ACGME Accredited? Yes ☐ No ☐

Start date _____ Graduation Date _____

Program Director _____ Program Director Phone _____

Program Director Email _____

Other: Institution _____

Specialty _____ ACGME Accredited? Yes ☐ No ☐

Start date _____ Graduation Date _____

Program Director _____ Program Director Phone _____

Program Director Email _____

Have you experienced any extensions, leaves of absence, gaps, or breaks in your medical education or training program due to repeated or remediation coursework, professionalism sanctions, or any other adverse actions by your medical school, training program, or sponsoring institution? Yes ☐ No ☐

If yes, please provide an explanation with details.

Are you able to perform, with or without reasonable accommodation, the essential functions of the position for which you are applying (as outlined on the OhioHealth Medical Education program webpage)? Yes ☐ No ☐

Licensure and Malpractice

Current medical license: State _____ Number _____ Expiration _____ Type Select from Dropdown

Current DEA license: Number _____ Expiration _____ Type Select from Dropdown

Some of our fellowships require a permanent license and federal DEA. If this applies to you are you able to obtain an Ohio medical license and federal DEA? Yes ☐ No ☐

Is there anything in your past history that limits your ability to be licensed or limits your ability to receive hospitals privileges? If yes, please provide details. Yes ☐ No ☐

Has your license or training permit in any state or jurisdiction ever been suspended, revoked, or voluntarily surrendered? If yes, please provide details. Yes ☐ No ☐

Have you ever practiced under a different name? If yes, please provide name(s). Yes ☐ No ☐

Have you ever been named in a malpractice case? If yes, please provide details. Yes ☐ No ☐

Examinations

Exam 1 Select from dropdown _____ Score _____ Date _____

Exam 2 Select from dropdown _____ Score _____ Date _____

Exam 3 Select from dropdown _____ Score _____ Date _____

Other _____ Score _____ Date _____

ECFMG Certificate Number _____ Expiration Date M/D/Y or Indefinite _____

Additional Questions

Are you committed to fulfill a US military active duty service obligation/deferment? Yes ☐ No ☐

If yes, number of years remaining _____ Branch _____

Do you have any other service obligations (e.g., military reserves, public health/state programs)? Yes ☐ No ☐

In compliance with federal law, all persons hired will be required to verify identity and eligibility to work in the United States and to complete the required employment eligibility verification form upon hire.

Are you authorized to work for any employer in the United States? Yes ☐ No ☐

Will you now or in the future require sponsorship for an employment visa? Yes ☐ No ☐

Have you ever been convicted of a crime (to include DUI, OVI, and or OMVI) other than minor traffic violation? If yes, please provide details. Yes ☐ No ☐

Meaningful Experiences

Please describe any meaningful experiences, rotations, or courses you have completed in the specialty for which you are applying.

For ONMM applicants only:

If you have attended a cranial course, please list the sponsoring organization and dates.

Please list completed NMM, OMM, ONMM rotations.

Additional Requested Items

These documents must be submitted along with this application unless noted:

Curriculum Vitae
Personal Statement
Copy of Residency Completion Certificate (if applicable)
3 Letters of recommendation (one from your current program director if applicable) sent directly from reference

Signature and Release

I certify that the information contained in this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position, or, if employed, may constitute for termination from the program. I authorize OhioHealth to verify any of the information I have provided, and further authorize any of the schools, institutions, or persons listed to provide any information about me contained in their records. If I am accepted for any position by OhioHealth, I agree to abide by the policies, rules, regulations and practices of OhioHealth and the training program. I agree to waive the right under the federal disclosure law to view my recommendations or interview evaluations.

Signature _____ **Date** _____