

**Application for Rotating/Elective Graduate Medical  
 Education Appointment  
 Trainee & Alumni Affairs**

**I. General Instructions**

Use the enclosed set of forms to apply for a rotating appointment to any graduate medical education program at The University of Texas M. D. Anderson Cancer Center. Submit a complete set of application materials as listed below to each program director, as appropriate. Materials submitted separately must contain the same surname and social security number as the application form.

<b>Required Documents</b>
Application Form – Submit an original application form and one photocopy. Supply <b>all</b> information requested; do not overlook signature, social security number, appropriate time frames or the required photocopies.
Letter of Recommendation – The letter must be from the clinical training program director of the parent program and dated no more than one year prior to the application date. The letter must reflect the applicant’s standing in the parent program and include proof of professional liability coverage provided by the parent institution for the elective rotation. Letter must also state that trainee is in compliance with the health screening policy of the parent institution.

**II. Program Requirements**

- A. Some programs require a personal interview prior to acceptance. Each program will communicate directly with its applicants concerning the review process and interview requirements.
- B. Additional documentation may be required by the programs.

**III. Policies Regarding Approval**

- A. Approval of recommendations, submitted by the training program director, is at the discretion of the Vice President for Academic Affairs. Questions concerning the status of a completed application should be directed to the clinical training program director of the program(s) to which application is made.
- B. The M. D. Anderson Cancer Center is an EOE employer and does not discriminate on the basis of race, color, national origin, gender, sexual orientation, age, religion, disability or veteran status, except where such distinction is required by law. All positions at The University of Texas M. D. Anderson Cancer Center are security sensitive and subject to Texas Education Code 51-215, which authorizes the employer to obtain criminal history record information. Smoke-free environment.
- C. In compliance with H.B. 558 passed during the 76<sup>th</sup> legislative session, The University of Texas System requires male citizens/nationals who are 18 to 26 years of age to provide proof of registration with the Selective Service System or exemption from registration, prior to employment. If you have not registered you may do so on line at: <https://www4.sss.gov/regver/register1.asp>.
- D. An appointment is contingent on obtaining a Postgraduate Resident Permit, required by the Texas State Board of Medical Examiners. Additional documentation to obtain a Postgraduate Resident Permit will be required at the time of acceptance.
- E. Appointees must provide suitable documentation of immunization or immunity for various communicable diseases prior to starting a clinical program.

Type or print information in black ink.

**IV. Biographical Information**

Full Name: \_\_\_\_\_  
Last or Family First Middle Maiden

U. S. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_  
No. and Street Apartment No.

\_\_\_\_\_ City State Zip Country

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Permanent Mailing Address: \_\_\_\_\_  
No. and Street Apartment No.

\_\_\_\_\_ City State Zip Country

Permanent Message Contact: \_\_\_\_\_  
Name Relationship Phone

Country of Citizenship or Last Permanent Residency: \_\_\_\_\_

If U. S. Citizen, Naturalized?  Yes  No If Non-U. S. Citizen, Current Visa Status: \_\_\_\_\_

Have you ever been convicted of a felony?  Yes  No If yes, give details of conviction including dates.

\_\_\_\_\_

**V. Academic History**

A. List all colleges and universities attended in chronological order, beginning with the most recent institution. Do not abbreviate names.

<b>Dates Attended From/To (mo/day/yr)</b>	<b>Institution City/State/Country</b>	<b>Major Field of Study</b>	<b>Degree</b>	<b>Date Awarded or Expected (mo/day/yr)</b>

**V. Academic History (Continued)**

B. List all graduate medical education training in chronological order, beginning with the most recent institution. Do not abbreviate names.

<b>Dates – From/To (mo/day/yr)</b>	<b>Sponsoring Institution and Address</b>	<b>Program Name</b>	<b>PGY Level</b>

**VI. American Specialty Board Certification**

List all Board Certifications.

<b>American Board Name</b>	<b>Date of Certification (mo/day/yr)</b>	<b>Recertification Required (yes/no)</b>	<b>Latest Date of Recertification (mo/day/yr)</b>

**VII. Professional Data**

A. List all active and inactive medical licenses. Attach a photocopy of active medical licenses.

<b>State</b>	<b>License Number</b>	<b>Year Issued</b>	<b>Expiration Date (mo/day/yr)</b>

**VII. Professional Data (Continued)**

- B. DEA Registration Number: \_\_\_\_\_ Attach a copy of your current DEA registration.
- C. DPS Controlled Substances Registration Number: \_\_\_\_\_ Attach a copy of your current registration.
- D. Has your license to practice medicine in the U. S. ever been denied, limited, suspended, revoked or not renewed?  
 Yes       No
- E. Have any disciplinary actions been initiated or are any pending against you by any State Licensure board?  
 Yes       No
- F. Has your Federal/State controlled substances or narcotics registration ever been limited, revoked, suspended or not renewed, voluntarily or involuntarily, and is such registration subject to any pending challenge?  
 Yes       No

G. Licensure Examination History for FLEX, NBME, and USMLE attempts:

Examination	Component	Date of Examination (mo/day/yr)	Pass (yes/no)

**VIII. Acknowledgement**

**Read the following statements carefully before signing your application.**

I understand that all application material submitted to The University of Texas M. D. Anderson Cancer Center becomes the property of M. D. Anderson and is not returnable. I also understand that M. D. Anderson is not obligated to furnish me with duplicate copies.

I understand that the information submitted herein will be relied upon by M. D. Anderson to determine my qualifications and eligibility for appointment and training. I authorize M. D. Anderson to verify the information I have provided. I understand that any omission of requested data may jeopardize my admission or subsequent academic standing at M. D. Anderson. I agree to notify the proper M. D. Anderson officials of any changes in the information provided.

I certify that the information in the application is complete, correct and not misleading to the best of my knowledge and belief. I acknowledge the submission of any false, incomplete or misleading information is grounds for rejection of my application, withdrawal of any acceptance offer, appointment revocation or appropriate disciplinary action after appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**IX. Release of Information**

I hereby authorize all hospitals, schools, physicians, employers, individuals, agencies or other organizations to provide M. D. Anderson (or its designee) with information requested by M. D. Anderson to verify the information I have provided in this application and to determine my qualifications and eligibility for appointment and training. I further agree not to hold such organizations (nor individuals employed by such organizations) liable for furnishing same.

Signature \_\_\_\_\_ Date \_\_\_\_\_