

2. Recent documents TST test or recent chest x-ray (<1year) if known TST positive
3. Proof of hepatitis B immunity (serology)
4. Proof of bloodborne pathogen training or training will be provided prior to starting rotation

DO YOU HAVE A FLORIDA MEDICAL LICENSE NUMBER? IF YES, PLEASE SUBMIT A COPY OF YOUR MEDICAL LICENSE.

No

Yes Number: _____ Permanent: _____ Training Certificate: _____

Are you aware of any limitation that would prevent you from performing the duties of the training position for which you are applying?

No

Yes Explain: _____

DO YOU HAVE A NARCOTIC REGISTRY LICENSE IN FLORIDA (DEA)? IF YES, PLEASE SUBMIT A COPY OF YOUR DEA CERTIFICATE. No

Yes DEA Number: _____

Are you a citizen of the United States? Yes No Type of Visa: _____

INTERNATIONAL MEDICAL GRADUATES ONLY:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

No Yes Certificate number _____ Certification valid through date: _____

Examination Taken

VQE 1 _____ 2 _____

NBME 1 _____ 2 _____

FMGEMS 1 _____ 2 _____

USMLE 1 _____ 2 _____

PLEASE SUBMIT A COPY OF YOUR CURRENT VALID ECFMG CERTIFICATE.

I certify that the information given on this form is true, accurate and complete.

Signature of Applicant Date _____

FOR CLEVELAND CLINIC FLORIDA USE ONLY:

Approved by:

Department Program Director or Supervising Physician

Chairman, Graduate Medical Education Committee