LSU Health
SHREVEPORT

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT & AFFILIATED HOSPITALS
1501 Kings Highway •P.O. Box 33932•Shreveport, LA 71130-3932
Telephone: (318) 675-5053 / Fax: (318) 675-5069

ATTACH ONE
(1) ORIGINAL
PHOTOGRAPH

APPLICATION FOR RESIDENCY/FELLOWSHIP PROGRAM

START DATE: MARK APPROPRIATE LEVEL: ☐PGY I ☐PGY II ☐PGY III ☐PGY IV ☐PGY V ☐PGY VI ☐PGY VI ☐PGY VII

TRAINING PROGRAM:

☐ Anesthesiology
☐ Emergency Medicine
☐ EM/FM
☐ Family Medicine – Alexandria
☐ Family Medicine – Shreveport
☐ Family Medicine – EA Conway
☐ Family Medicine – North Caddo
☐ Internal Medicine - Prelim
☐ Internal Medicine
☐ Medicine/Pediatrics
☐ Neurology
☐ Neurosurgery
☐ Obstetrics & Gynecology
☐ Ophthalmology
☐ Oral Surgery
☐ Orthopaedic Surgery
☐ Otolaryngology
☐ Pathology
☐ Pediatrics
☐ Psychiatry
☐ Radiology
☐ Surgery – Prelim
☐ Surgery
☐ Urology

FELLOWSHIP:
☐ Pain Management
☐ Cardiology
☐ Interventional Cardiology
☐ Critical Care Medicine
☐ Endocrinology
☐ Gastroenterology
☐ Hematology/Oncology
☐ Sleep Medicine
☐ Infectious Diseases
☐ Nephrology
☐ Pulmonary/Critical Care
☐ Rheumatology
☐ Cytopathology
☐ Allergy/Immunology
☐ Child & Adolescent Psychiatry
☐ Forensic Psychiatry
☐ Colon&Rectal Surgery
☐Oral Surgery
☐Other

PERSONAL INFORMATION

LEGAL LAST NAME	LEGAL FIRST NAME	MIDDLE INITIAL	TITLE (MD, DO, DDS, ETC.)

DATE OF BIRTH	PLACE OF BIRTH	**US** SOCIAL SECURITY # (Provide copy)	SEX: ☐Female ☐Male

CITIZENSHIP STATUS ☐US Citizen ☐J-1 (attach proof) ☐Permanent Resident/Exp:__________(attach proof)	RACIAL/ETHNIC GROUP:	PLEASE LIST ANY OTHER FOREIGN LANGUAGE SKILLS: Language: _____ ☐Speak ☐Read ☐Write Language: _____ ☐Speak ☐Read ☐Write

MARITAL STATUS ☐Single ☐Married ☐Divorced ☐ Widowed	IF MARRIED, SPOUSE'S NAME	PERSONAL EMAIL (**not** school issued email)

MAILING ADDRESS	CITY	STATE	ZIP	CELL/HOME PHONE
EMERGENCY CONTACT	CITY	STATE	ZIP	CONTACT PHONE

EDUCATION (PREMEDICAL)

COLLEGE/UNIVERSITY SCHOOL NAME	DATES ATTENDED From: To:	GRADUATION DATE	DEGREE

EDUCATION (MEDICAL/DENTAL)

MEDICAL/DENTAL SCHOOL NAME	DATES ATTENDED From: To:	GRADUATION DATE	DEGREE

LICENSURE

PLEASE INDICATE ONE: ☐US Graduate ☐Non US Foreign Medical School Graduate	ECFMG# (Attach Certificate) DATE ISSUED	NATIONAL PROVIDER IDENTIFIER (NPI)

LICENSED TO PRACTICE MEDICINE IN THE STATE(S) OF	LICENSE #(S)	DATES TAKEN AND RESULTS OF USMLE (Attach copies of ALL test results) I _____ II _____ III _____ FLEX _____ National Board _____

ALL APPLICANTS MUST MEET THE LICENSING REQUIRMENTS OF THE LOUISIANA STATE BOARD.

TRAINING

Please provide any prior internship/residency/fellowship training.
Provide copies of any certificates received.

TYPE OF TRAINING ☐Internship ☐Residency ☐Fellowship	TYPE OF INTERNSHIP/RESIDENCY/FELLOWSHIP	DATES ATTENDED From: To:

NAME OF INSTITUTION	ADDRESS	CITY	STATE	ZIP

TYPE OF TRAINING ☐Internship ☐Residency ☐Fellowship	TYPE OF INTERNSHIP/RESIDENCY/FELLOWSHIP	DATES ATTENDED From: To:

NAME OF INSTITUTION	ADDRESS	CITY	STATE	ZIP

TYPE OF TRAINING ☐Internship ☐Residency ☐Fellowship	TYPE OF INTERNSHIP/RESIDENCY/FELLOWSHIP	DATES ATTENDED From: To:

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PHYSICIAN REFERENCES

(Supervisor/ Preceptor/ Program Director/ Etc.)

NAME	ADDRESS	CITY	STATE	ZIP
NAME	ADDRESS	CITY	STATE	ZIP
NAME	ADDRESS	CITY	STATE	ZIP

Please answer the following questions. Any "YES" response will require an explanation on a separate sheet.	YES	NO
1. Do you have or have you ever had a physical or mental condition, which in any way could impair your ability to practice medicine or in any way poses a potential or actual risk or harm to your patients?	☐	☐
2. Have you ever been affected by or sought counseling or treatment for drug use, chemical or alcohol dependency or behavioral problems?	☐	☐
3. Are you now or have you ever been a patient in the psychiatric unit of a hospital/clinic?	☐	☐
4. Are you currently taking any medication, which could affect your clinical judgment or motor skills?	☐	☐
5. Have you ever been charged with, and/or convicted of, pled guilty or nolo contendere to, any violation of any municipal, county/parish, state or federal statute; are any charges pending against you at this time? (Should not include minor traffic citations.)	☐	☐
6. Have you ever been denied a professional license, resident permit, or certification by any licensing or certifying board or agency and/or are there any actions, proceedings or investigations, past or pending, related to your license, permit or certification?	☐	☐
7. Have you ever failed a licensure/certification examination? (USMLE, COMLEX, TOEFL, etc.) If yes, how many times ( )	☐	☐
8. Have you ever been denied membership in a state, county, or local professional society? Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?	☐	☐
9. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished staff or clinical privileges in any hospital or health care institution or organization?	☐	☐
10. Have you had any malpractice claims filed against you within the last five (5) years?	☐	☐
11. Do you have a federal or state controlled substance permit? If yes, provide copies.	☐	☐
12. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?	☐	☐
13. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?	☐	☐
14. Have you ever been the subject of any type of disciplinary action or inquiry including fraud by any licensing agency, hospital, institution, society, etc.?	☐	☐
15. Have you ever received notice of termination or been sanctioned, monitored (excluding random monitoring), or excluded from status as a supplier of services under the Medicare, Medicaid, CLIA, Champus or any other Federal or State government programs?	☐	☐
16. Have you ever been subject to any type of disciplinary action, terminated or dismissed from any previous training program?	☐	☐
17. Have you ever agreed to not seek re-licensure in any licensing jurisdiction?	☐	☐
18. Have you ever initiated a proceeding, suit, or action against another provider or institution?	☐	☐

NOTE: You are required to answer every question. Failure to do so will result in a delay or perhaps even cause your appointment to become null and void. Failure to answer all questions truthfully shall be grounds for immediate termination and/or dismissal from the training program and forfeit your right to appeal. You may be required to provide additional information to complete the processing of your application

ALL APPLICANTS: Request a copy of your transcript, Dean's letter and three (3) physician reference letters be sent to the Program Director of the program to which you are applying. The program should be referenced and a biographical statement should accompany your application.

In making this application, I fully understand that it is my duty to promptly report any changes in the response(s) to the questions resulting during my practice in this Institution, or any other setting or institution, and that failure to do so shall constitute cause for summary suspension and dismissal from the training program. I do hereby also specifically authorize the hospital and release it, its representatives, and all organizations and individuals who provide information to the hospital from liability in their obtaining information regarding any changes or potential changes in my response to these questions. I hereby waive all rights I may have against any person, institution, or organization conveying such information or releasing such information to LSU Health Sciences Center.

Applicant Signature: _____ Date: _____