

Basic Information

| | |
|-----------------------------|---|
| First Name* | Email* |
| Middle Name | Birth Date* |
| Last Name* | |
| Suffix <input type="text"/> | I authorize the release of my birth date to programs <input type="checkbox"/> |

Work Authorization

| | | | | |
|---|------------|--------------|-----|------|
| Are you currently authorized to work in the United States?* | Yes | No | | |
| What is your current work authorization?* | US Citizen | J-I Clinical | EAD | H-1B |

Additional Information

| | | |
|---|-----|----|
| Was your medical education/training extended or interrupted?* | Yes | No |
|---|-----|----|

If yes, please provide details or attachment:

| | | |
|---|-----|----|
| Have you ever been on academic probation, remediation, or held back from an education/training program? | Yes | No |
|---|-----|----|

If yes, please provide details or attachment:

| | | |
|---|-----|----|
| Has your employment ever been involuntary terminated or have you resigned in lieu of termination? | Yes | No |
|---|-----|----|

If yes, please provide details or attachment:

| | | |
|---|-----|----|
| Have you ever been on Administrative Leave from your program for investigations in relations to disciplinary, professionalism and medical practices? If yes, please provide details or attachment: | Yes | No |
|---|-----|----|

Licensure

Please add an entry for your most recent state medical licenses.

None

State*

License Type*

License Number*

Expiration Month*

Expiration Year*

Additional Information

Has your medical license ever been suspended/revoked/
voluntarily terminated?*

Yes No

If yes, please provide details:

Have you been named in a malpractice case? Yes No

If yes, please provide details:

Do you have a physical, medical (including substance abuse), mental or emotional condition that could affect your ability to
exercise the clinical privileges requested safely and competently? Yes No

Have you ever been convicted of a misdemeanor in the United States?*

Yes No

If yes, please explain or provide attachment:

Have you ever been convicted of a felony in the United States?*

Yes No

If yes, please explain or provide attachment:

Are you able to carry out the responsibilities of a resident, intern, or a fellow in the specialties and at the specific training programs to
which you are applying, including the functional requirements, cognitive requirements, and interpersonal and communication requirements
with or without reasonable accommodations?*

Yes No No Response

Certification

I certify that the information contained within the 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; may result in an investigation by the University of Florida, College of Medicine, or if employed, may constitute cause for termination from the program.

Use and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data and to the University of Florida, College of Medicine's collection and other processing of my personal data according to University of Florida privacy policies.

Signature

Date