Department of Medicine

UPSTATE MEDICAL UNIVERSITY
COLLEGE OF MEDICINE

Application for Observership Rotation
Department of Internal Medicine
SUNY Upstate Medical University

Applicant Information

Full Name: _____ Date: _____
Last *First* *Middle name*

Other names you have used: _____

Name you would like to be called: _____

Date of birth: _____ Nationality: _____ Gender: _____
MM/DD/YYYY **M or F**

Date of availability to start the observership : _____ Visa Status: _____
MM/DD/YYYY

Will you have a car during your rotations? _____

Current Mailing address in the USA: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: **( )** _____ E-mail Address: _____
NOTE: Email will be the method of communication between the Upstate and the Applicant

Permanent Mailing Address: _____

References- Include the name of a physician who has provided a reference/LOR

Name and Current Mailing address _____
Name

_____
Address

_____
Address

Education- List the name of each institution attended. Provide the address of the institution and the dates of attendance. Use a sheet of paper if needed.

1. Name and address: _____
Name *Address*

_____
Degree/certificate *Dates attended*

2. Name and address: _____
Name *Address*

_____
Degree/certificate *Dates attended*

3. Name and address: _____

Name *Address*

_____

Degree/certificate *Dates attended*

4. Name and address: _____

Name *Address*

_____

Degree/certificate *Dates attended*

USMLE Scores

1. Step I: Date _____ Score _____ **1st Attempt** **YES** ☐ **NO** ☐

2. Step II: Date _____ Score _____ **1st Attempt** **YES** ☐ **NO** ☐

3. Step II CSA: Date _____ Score _____ **1st Attempt** **YES** ☐ **NO** ☐

4. Step III: Date _____ Score _____ **1st Attempt** **YES** ☐ **NO** ☐

Postgraduate Experience: List the name and address of each program and/or experience attended regardless of whether the program was completed or credit was received

1. Name and address: _____

Name *Address*

_____

Degree/certificate *Dates attended*

2. Name and address: _____

Street Address *Apartment/Unit #*

_____

City *Degree/certificate* *Dates attended*

3. Name and address: _____

Street Address *Apartment/Unit #*

_____

City *Degree/certificate* *Dates attended*

4. Name and address: _____

Street Address *Apartment/Unit #*

_____

City *Degree/certificate* *Dates attended*

Questions

	YES	NO
Is any criminal action pending against you?	☐	☐
Are you required to register as a Sex Offender?	☐	☐
Have you ever been denied a license to practice medicine in any country?	☐	☐
Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical board, other agency or hospital?	☐	☐
Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	☐	☐
Have you been treated for or had a recurrence of a diagnosed addictive disorder?	☐	☐
Do you have any other condition which in any way impairs or limits your ability to practice medicine safely?	☐	☐

If yes to any, explain:

Complete application packet

- Completed application form
- Completed ranking of requested rotations
- Resume or Curriculum Vitae
- Proof of Up-To-Date immunizations
- Evidence of completion of medical education, including Medical School Transcript, if available
- USMLE Score Reports
- ECFMG certificate, if applicable
- Copy of visa, if applicable
- Copy of passport, if applicable - information page, picture page, signature page, inside back cover page
- 1 passport photo
- $300 cashier's check or money order for the non-refundable application fee made out to the Upstate Medical University Department of Medicine / MSG. ***Personal Checks will not be accepted.***

Any document that is written in a language other than English must be accompanied by an original, official translation.

Please **mail** the completed packet to the following address. Documents that are emailed or faxed will not be accepted.

Upstate Medical University
Department of Medicine
Attn: Observership Program, Room 5138 UH
750 E. Adams St.
Syracuse, NY 13210

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I have read the Observership Policy Overview and submit my application for the Observership Program at SUNY Upstate Medical University, Department of Medicine.

Signature: _____ Date: _____

Applicant

OFFICE USE ONLY

Applicant is approved for the following rotations:

Dates: _____ Rotation: _____ Payment Received: _____

Dates: _____ Rotation: _____ Payment Received: _____

Dates: _____ Rotation: _____ Payment Received: _____

Dates: _____ Rotation: _____ Payment Received: _____

DEPARTMENT APPROVAL

This application is approved for the rotations described above. These rotations will be closely monitored to ensure that the applicant adheres to the Observership Policies of the Department of Medicine and the Institutional Policies of the Medical Staff Office of Upstate Medical University.

Signature: _____ Date: _____

Department of Medicine Program Director or Chair