Department of Urology

UPSTATE MEDICAL UNIVERSITY
COLLEGE OF MEDICINE

Application for Observership Rotation

Department of Urology
SUNY Upstate Medical University

Application Information:

Full Name:

Last: _____ First: _____ Middle Name: _____ Date: _____

Other Names you have used: _____

Name you would like to be called: _____

Date of Birth (MM/DD/YYYY): _____ Nationality: _____ Gender (M or F): _____

Date of Availability to Start the Observership (MM/DD/YYYY): _____ Visa Status: _____

Will you have a car during your rotations? ☐ Yes ☐ No _____

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 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: _____

Street Address: _____

City/State/Zip: _____

★ Education: List the name of each institution attended. Provide the address of the institution and the dates of attendance.

1. Name: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

2. Name: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

★ = Medical Students / Residents only

3. Name: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

4. Name: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

Use a sheet of paper if needed.

★ 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: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

2. Name: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

3. Name: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

4. Name: _____ Address: _____

   Degree / Certificate: _____ Dates Attended: _____

Questions:

Is any criminal action pending against you? . . . . . ☐ Yes ☐ No

Are you required to register as a Sex Offender?. . . . . ☐ Yes ☐ No

Have you ever been denied a license to practice medicine in any country?. . . . . ☐ Yes ☐ No

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, or other agency or hospital? . . . . . ☐ Yes ☐ No

Have you been enrolled in, requred to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?. . . . . ☐ Yes ☐ No

Have you been treated for or had a recurrence of a diagnosed addictive disorder? . . . . . ☐ Yes ☐ No

Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? . . . . . ☐ Yes ☐ No

If Yes to any, explain: _____

_____

Complete Application Packet:

- Complete application form
- Resumé or Curriculum Vitae
- Proof of Up-To-Date Immunizations
  Evidence of completion of medical education, including Medical School Transcript, if available, if applicable
- USMLE Score Reports, if applicable
- 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
- $400 cashier's check or money order for the non-refundable application fee made out to the Upstate Medical University Department of Urology ***Personal checks will not be accepted.***

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

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

Upstate Medical University
Department of Urology
Attn: Observership Program, CWB 218A
750 E. Adams Street
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 Urology.

Applicant Signature: _____ Print Name: _____ Date: _____

Office Use Only:

Applicant is approved for the following rotations:

Dates: _____ Rotation: _____ Payment Received: _____

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Departmental 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 Urology and the Institutional Policies of the Medical Staff Office of Upstate Medical University.

Department of Urology Program Director or Chair

Signature: _____ Print Name: _____ Date: _____