



Application for Observership Rotation
Department of Neurology
SUNY Upstate Medical University

Applicant 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?
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
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	1 st Attempt	Y or N
2. Step II:	Date	Score	1 st Attempt	Y or N
3. Step II CSA:	Date	Score	1 st Attempt	Y or N
4. Step III:	Date	Score	1 st Attempt	Y or N

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:	_____	_____	_____	_____
	<i>Name</i>	<i>Address</i>		
	_____	_____	_____	_____
		<i>Degree/certificate</i>	<i>Dates attended</i>	
2. Name and address:	_____	_____	_____	_____
	<i>Street Address</i>	<i>Apartment/Unit #</i>		
	_____	_____	_____	_____
	<i>City</i>	<i>Degree/certificate</i>	<i>Dates attended</i>	
3. Name and address:	_____	_____	_____	_____
	<i>Street Address</i>	<i>Apartment/Unit #</i>		
	_____	_____	_____	_____
	<i>City</i>	<i>Degree/certificate</i>	<i>Dates attended</i>	
4. Name and address:	_____	_____	_____	_____
	<i>Street Address</i>	<i>Apartment/Unit #</i>		
	_____	_____	_____	_____
	<i>City</i>	<i>Degree/certificate</i>	<i>Dates attended</i>	

Questions

Is any criminal action pending against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you required to register as a Sex Offender?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever been denied a license to practice medicine in any country?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you been treated for or had a recurrence of a diagnosed addictive disorder?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have any other condition which in any way impairs or limits your ability to practice medicine safely?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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
- \$150 cashier's check or money order for the non-refundable application fee made payable to Neurology Medical Service Group, LLP.

***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 Neurology
Attn: Observership Program, Room JH 812
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 Neurology.

Signature: _____ Date: _____
Applicant

OFFICE USE ONLY

Applicant is approved for the following rotations:

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 Neurology and the Institutional Policies of the Medical Staff Office of Upstate Medical University.

Signature: _____ Date: _____