



# AMERICAN OSTEOPATHIC ASSOCIATION

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**This Universal Application was developed in collaboration with Association of Osteopathic Directors and Medical Educators**

## OSTEOPATHIC POSTDOCTORAL TRAINING APPLICATION

This application may be printed and completed off-line and then sent to your selected sites for internship/residence selection. Please note that training institutions may request supplemental information.

All required fields are marked with an asterisk (\*). Please note, however, that some of these fields are required only in certain circumstances. For example, if you state that you did earn or expect to receive a degree from an institution, you will be required to enter what that degree is.

### Personal Information \*

Full Name	Other Name/Nickname	
Gender (F=female, M=Male)	SSN	Birth Date
AOA Number	Birth Place	
Select Citizenship Type (dropdown box)	Select Visa Type (dropdown box)	

### Contact Address \*

Street Address	City	State
Zip Code	Country	Contact Phone
Contact Email:		Alternate Phone:

### Home/Alternate Address \*

Street Address	City	State
Zip Code	Country	Contact Phone
		Alternate Phone

### Program Selection \*

Osteopathic Graduate Medical Education Year (dropdown box):

If Internship (dropdown box):  
 (If Specialty Track, Special Emphasis, or Linked, specify interest:

If Residency (specify interest)

If Sub-Specialty (specify interest)

### Military Obligation \*

Are you committed to fulfill a U.S. Military active duty service obligation (Y=Yes, N=No):

If YES, Years of Commitment:      Start Month:      Start Year:

### Non-Medical Undergraduate Education \*

For each undergraduate institution you have attended, please provide the following information. This worksheet has space for you to make 2 entries.

**#1**  
Institution City, State, Country  
Major Degree expected or earned (Y=Yes, N=No) Degree Degree Date (month/year)  
Dates of Attendance: From (month/year): To (month/year):

**#2**  
Institution City, State, Country  
Major Degree expected or earned (Y=Yes, N=No) Degree Degree Date (month/year)  
Dates of Attendance: From (month/year): To (month/year):

Check here if you attended more than two non-medical undergraduate institutions.

**Non-Medical Graduate Education \***

For each graduate-level institution you have attended, please provide the following information. This worksheet has space for you to make 2 entries.

None

**#1**  
Institution City, State, Country  
Major Degree expected or earned (Y=Yes, N=No) Degree Degree Date (month/year)  
Dates of Attendance: From (month/year): To (month/year):

**#2**  
Institution City, State, Country  
Major Degree expected or earned (Y=Yes, N=No) Degree Degree Date (month/year)  
Dates of Attendance: From (month/year): To (month/year):

Check here if you attended more than two non-medical graduate institutions.

**Undergraduate Medical Education \***

For each medical school you have attended, please provide the following information. This worksheet has space for you to make 2 entries.

**#1**  
Institution City, State, Country  
Major Degree expected or earned (Y=Yes, N=No) Degree Degree Date (month/year)  
Dates of Attendance: From (month/year): To (month/year):

**#2**  
Institution City, State, Country  
Major Degree expected or earned (Y=Yes, N=No) Degree Degree Date (month/year)  
Dates of Attendance: From (month/year): To (month/year):

Check here if you attended more than two medical undergraduate institutions.

**Residencies/Fellowships \***

For each internship or residency position you have held, please provide the following information. This worksheet has space for you to make 2 entries.

None

**#1**

Specialty: Institution/Program:  
City State/Province Country:  
Program Director Supervisor:  
Years Dates of Residency  
From (month/year): To (month/year):  
Reason for leaving:

**#2**

Specialty: Institution/Program:  
City State/Province Country:  
Program Director Supervisor:  
Years Dates of Residency  
From (month/year): To (month/year):  
Reason for leaving:

Check here if you attended more than two residency programs.

**Work Experience(s) \***

For each work experience position you have had, please provide the following information. This worksheet has space for you to make 2 entries.

None

**#1**

Organization Position  
Description  
If no, the reason for leaving:  
Dates of Experience: From (month/year): To (month/year):

**#2**

Organization Position  
Description  
If no, the reason for leaving:  
Dates of Experience: From (month/year): To (month/year):

Check here if you held more than two work positions.

**Leadership, Extra-Curricular, and Volunteer Experiences**

For each experience you have had, please provide the following information. This worksheet has space for you to make 2 entries.

None

**#1**

Organization

Position

Description

Dates of Experience: From (month/year):

To (month/year):

**#2**

Organization

Position

Description

Dates of Experience: From (month/year):

To (month/year):

**Please list the honor societies for which you are a member:**

**Research Experience \***

For each experience you have had, please provide the following information. This worksheet has space for you to make 2 entries.

None

**#1**

Organization

Position

Description

Dates of Experience: From (month/year):

To (month/year):

**#2**

Organization

Position

Description

Dates of Experience: From (month/year):

To (month/year):

**Publications \***

(Use also for Poster Sessions/Abstracts/Invited National or Regional Presentations). For each publication/presentation you have had, please provide the following information.

None

**#1**

Publication/Presentation Citation:

**#2**

Publication/Presentation Citation:

Check here if you have more than two published articles and presentations.

**Medical Licensure \***

Current Medical Licensure (dropdown box)

Has your Medical License ever been suspended/revoked/voluntarily terminated? (Y=Yes, N=No)

If YES, please provide explanation:

Have you ever been named in a malpractice case? (Y=Yes, N=No)

If YES, please provide explanation:

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges? (Y=Yes, N=No)

If YES, please provide explanation:

Have you ever been convicted of a felony? (Y=Yes, N=No)

If YES, please provide explanation:

**Examinations \***

For each examination you have taken, please provide the following information.

COMLEX I	COMLEX II	COMLEX III
<input type="checkbox"/> Score: <input type="checkbox"/> Passed on <input type="checkbox"/> Failed on <input type="checkbox"/> Awaiting results from <input type="checkbox"/> Will take on <input type="checkbox"/> Will retake on	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on <input type="checkbox"/> Failed on <input type="checkbox"/> Awaiting results from <input type="checkbox"/> Will take on <input type="checkbox"/> Will retake on	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on <input type="checkbox"/> Failed on <input type="checkbox"/> Awaiting results from <input type="checkbox"/> Will take on <input type="checkbox"/> Will retake on

USMLE I	USMLE II	USMLE III
<input type="checkbox"/> Score: <input type="checkbox"/> Passed on <input type="checkbox"/> Failed on <input type="checkbox"/> Awaiting results from <input type="checkbox"/> Will take on <input type="checkbox"/> Will retake on	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on <input type="checkbox"/> Failed on <input type="checkbox"/> Awaiting results from <input type="checkbox"/> Will take on <input type="checkbox"/> Will retake on	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on <input type="checkbox"/> Failed on <input type="checkbox"/> Awaiting results from <input type="checkbox"/> Will take on <input type="checkbox"/> Will retake on

**All Applicants \***

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

- Yes
- No
- No Response

Limiting Aspects:

Was your medical education extended or interrupted?

- Yes
- No
- No Response

Reason:

**Personal Statement \***

Personal statement should include medical school awards, hobbies and interests, language fluency, (other than English), other awards and accomplishments, personal strengths, reasons for interest in specified hospital or specialty.

I have reviewed and completed this Osteopathic Postdoctoral Training Application Form. By submitting this form to a postdoctoral training program, I attest that the information I have provided on this form is true and accurate to the best of my knowledge. I understand that the postdoctoral training programs may seek proof or verification from me or third parties of the information provided on this form. I further understand and acknowledge that providing false information on this form is unethical and would constitute cause for my immediate termination from any training program that offers a position to me.