

**University of Texas M. D. Anderson Cancer Center**  
**Application for Full-time Graduate Medical Education Appointment**  
**Office of Education**

**I. General Instructions**

The enclosed set of forms must be used to apply for appointment to an elective rotation at any of the graduate medical education programs at The University of Texas M. D. Anderson Cancer Center. A complete set of application materials must be submitted to each program director as appropriate.

A. Please type or print all information and use black ink on all forms. An original application form and one photocopy must be submitted to begin the application process.

B. Please make the necessary arrangements to have all documents which constitute your application reflect one surname and social security number.

C. A complete application consists of the items listed below. All items should be submitted with the Application Information Form unless otherwise noted. Materials submitted separately must reflect the same surname and social security number as the Application Information Form.

**Clinical Trainee**

Application Information Form - Please type or print all information using black ink. Supply all information requested; do not overlook signature, social security number, the appropriate time frames, or the required photocopy.

Letters of Recommendation - Letters should be dated no more than one year prior to the application date. Letters must reflect appointment at the appropriate academic level and should be from persons qualified to comment on your qualifications in a laboratory or research as well as patient care setting.

Transcripts and Certificates - You should arrange for OFFICIAL TRANSCRIPTS to be sent directly to you in a sealed envelope containing the official letterhead from each medical school attended, even if transfer credit is shown at the most recent school attended. You must also send updated transcripts as additional course work is completed. You may submit photocopies of certificates of completion for all GME programs. You must also send updated certificates or statement of program completion from the clinical training program director as additional programs are completed.

International applicants should refer to the special instructions for additional information.

**II. Personal Interviews**

Some programs require a personal interview prior to acceptance. Each program will communicate directly with each applicant concerning the review process and interview requirements.

**III. Policies Regarding Acceptance**

1. All actions on acceptance are the prerogative of the Vice President of Academic Affairs at the recommendation of the Vice President for Academic Affairs at the recommendation of the program training director. Questions concerning the status of a completed application should be directed to the clinical training program director of the program(s) to which the application is made. Appointment is contingent on securing an Institutional Permit, required by the Texas State Board of Medical Examiners.
2. Additional documentation to secure an Institutional Permit will be required at the time of acceptance as described later in this document.
3. Appointees must provide suitable documentation of immunization or immunity for various communicable diseases prior to starting a clinical program. The Immunization Record Form is included in this packet for your review.
4. The University of Texas M. D. Anderson Cancer Center does not discriminate with regard to sex, race, color, age, creed, or national origin in judging an applicant's qualifications for admission.



### III. Academic History

A. List all colleges and universities attended (list chronologically beginning with current or most recent institution). Please **Do Not** abbreviate names.

Name of Institution & Location	Dates Attended From/To (Month/Year)	Major Field of Study	Degree	Date Awarded or Expected (Month/Year)

**Submit with your application packet official transcripts in sealed envelopes containing official letterhead**

B. List all graduate medical education training related to your academic goals (list chronologically beginning with current or most recent institution). Please **Do Not** abbreviate names.

Dates (M/Y) From To	Sponsoring Institution & Address	Program Title	PGY Level

**Submit with your application packet official transcripts in sealed envelopes containing official letterhead**

**IV. Professional Employment:** (List chronologically beginning with current or most recent.)

<b>Dates (M/Y) From To</b>	<b>Employer &amp; Address</b>	<b>Title</b>

**V. American Specialty Board Certification**

**Eligibility Status**

<b>American Board Name</b>	<b>Qualifying Exam Yes/No/Pending</b>	<b>Certifying Exam Yes/No/Pending</b>	<b>Clinical Assessment Yes/No/Pending</b>

List all board certifications

<b>American Board Name</b>	<b>Date of Certification (MM/DD/YY)</b>	<b>Recertification Required (Y/N)</b>	<b>Latest Date of Recertification (MM/DD/YY)</b>

**VI. Professional Data**

Licensure: List all (active and inactive) and attach a photocopy of current medical licenses

<b>State</b>	<b>License Number</b>	<b>Year Issued</b>	<b>Expiration Date</b>

DEA Registration Number: \_\_\_\_\_

Attach a copy of your current DEA registration

DPS Controlled Substances Registration Number \_\_\_\_\_

Attach a copy of your current registration

1. Has your license to practice medicine in the US ever been denied, limited, suspended, revoked, or not renewed?

Yes \_\_\_ No \_\_\_

2. Have any disciplinary actions been initiated or are pending against you by any State Licensure board?

Yes \_\_\_ No \_\_\_

3. Has your Federal/State controlled substances or narcotics registration ever been limited, revoked, suspended, or not renewed, voluntarily or involuntarily, and is such registration subject to any pending challenge?

Yes \_\_\_ No \_\_\_

**VII. Statement of Intent**

State your reasons for desiring graduate education in your chosen field. Include future career plans and how they might be enhanced by your additional training. Attach additional sheets as necessary.

**PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING YOUR APPLICATION.**

I understand that all application material submitted to The University of Texas M. D. Anderson Cancer Center becomes the property of this institution and is not returnable. I also understand that The University of Texas M. D. Anderson Cancer Center is not obligated to furnish me with duplicate copies.

I understand that the Information submitted herein will be relied upon by The University of Texas M. D. Anderson Cancer Center to determine my status for appointment and training eligibility. I authorize The University of Texas M. D. Anderson Cancer Center to verify the information I have provided. I understand that any omission of requested data may jeopardize my admission or subsequent academic standing at The University of Texas M. D. Anderson Cancer Center. I agree to notify the proper UTMDACC officials of any changes in the information provided.

I certify that the information in the application is complete and correct to the best of my knowledge and belief. I acknowledge the submission of any false information is grounds for rejection of my application, withdrawal of any acceptance offer, appointment revocation, or appropriate disciplinary action after appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Release of Reference** I release from liability and from any restrictions as to confidentiality or privacy all hospitals, schools, physicians, employers, individuals, agencies or organizations that provide information about me at the request of The University of Texas M. D. Anderson Cancer Center or its agents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Have you ever been employed by The University of Texas M. D. Anderson Cancer Center?** If yes, please list department and dates of service.

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**Have you ever been employed by another University of Texas component or another agency of the State of Texas?**

If yes, please list agency and dates of services.

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