



**ADDENDUM TO THE APPLICATION FOR A GRADUATE MEDICAL EDUCATION  
TRAINING POSITION AT UCSD MEDICAL CENTER  
2009-2010**

The information being sought on this form will be used by UCSDMC in its normal conduct of business relative to your postgraduate training at this institution. Pursuant to the federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is voluntary. This record keeping system was established pursuant to the authority of The Regents of the University of California, under Article IX, section 9, of the California Constitution. The social security number is used to verify your identity and shall not be disclosed except as permitted by law.

**Name** \_\_\_\_\_  
Last First Middle

**Other Last Name Used** \_\_\_\_\_  
(e.g., Maiden)

**Date of Birth** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**E-Mail Address** \_\_\_\_\_

**Residency Specialty for 2010-11: Ophthalmology**

Appointment Level: **PGY 2**

From – To Dates **July 1, 2009 to June 30, 2010**

**Number of years completed in all approved residency and clinical fellowship programs in the USA:**

<i>EXAMPLE #1</i>	<i>PROGRAM</i> Internal Med Med Cardiology	<i>YEAR(S) COMPLETED</i> 3 1	<i>DATE</i> 7/1/06-6/30/09 7/1/09-6/30/10
	TOTAL YEARS ALL PGME COMPLETED THROUGH 6/30/10	4	
<i>EXAMPLE #2</i>	Surgery Radiology	1 2	7/1/07-6/30/08 7/1/08-6/30/10
	TOTAL YEARS ALL PGME COMPLETED THROUGH 6/30/10	3	

**Enter your data here:**

	<i>PROGRAM</i>	<i>YEARS(S) COMPLETED</i>	<i>DATE</i>
Prior Training:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**TOTAL YEARS ALL PGME  
COMPLETED THROUGH  
6/30/10** \_\_\_\_\_



**Medical School:**

Name \_\_\_\_\_  
Degree Conferred \_\_\_\_\_  
Date of Graduation \_\_\_\_\_  
(Month/Year)

**Foreign Medical School Graduate (school not located in the USA or Canada):**

I have passed the following exam:  USMLE 1 Date \_\_\_\_\_  
 USMLE 2 Date \_\_\_\_\_  
 USMLE 3 Date \_\_\_\_\_  
 FMGEMS Date \_\_\_\_\_  
 NBME Date \_\_\_\_\_  
 Other ECFMG Exam Date \_\_\_\_\_

Please return a copy of your current ECFMG certificate with this form to Graduate Medical Education.

**Non-Citizen of United States:**

Class of Visa:  Alien Resident  
 J Visa issued by the ECFMG  
 Other – Please designate type \_\_\_\_\_

Date entered US \_\_\_\_\_

Intended Length of Stay \_\_\_\_\_

Please return a copy of your current visa with this form to Graduate Medical Education.

**Medical License(s) Outside of the State of California:**

	<i>Number</i>	<i>Expiration Date</i>	<i>State</i>
(1)	_____	_____	_____
(2)	_____	_____	_____

**NPI Number:** \_\_\_\_\_  
(National Provider ID)

Return this completed form and applicable attachments *within ten working days* to:

Office of Graduate Medical Education, 8829  
UCSD Medical Center  
200 West Arbor Drive  
San Diego, California 92103-8829