



# BAYLOR COLLEGE OF MEDICINE

## HOUSE STAFF APPLICATION

Optionally, provide a small  
passport style photograph  
in this space.

If applicable, are you registered with the National Resident Matching Program? \_\_\_\_\_

Application for house staff appointment (specialty)	Level of training applied for:	Beginning (MO) (DAY) (YEAR):
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Last	First	Middle	Present Address		
E-mail Address			Telephone (Hospital/School)	Social Security Number	
Telephone (Home)			Name and address of someone always able to contact you		
Permanent home address			Citizenship	If non-citizen, date of entry into U.S.	
Birthdate (MO)(DAY)(YR)	Place of Birth		In non-citizen, type of Visa held (Exchange Visitor, Immigrant, etc.)		
Do you have any condition which might impair your participation in the program? If so please describe.					

**EDUCATION:**

<b>High School</b>	Name	From	To	
	Address			
<b>College</b>		From	To	Degree
		From	To	Degree
<b>Medical School</b>	Name	From	To	Degree
	Address			

<p>If a graduate of a foreign medical school, have you obtained certification from the Educational commission for Foreign Medical Graduates? _____ Indicate exams passed: ECFMG _____, Visa Qualifying Examination (VQE) _____, Foreign Medical Graduate Exam in the Medical Sciences (FMGEMS) _____, National Board Exam (parts 1-2-3) _____, United State Medical Licensing Examination (USMLE) (steps 1-2-3) _____, or FLEX _____. Please enclose notarized copies of your exam results and ECFMG certificate.</p>
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<b>Internship</b>	Hospital	From	To	Field
		City and State		
<b>Residency</b>	Hospital	From	To	Field
		City and State		
	Hospital	From	To	Field
		City and State		
<b>Fellowship</b>	Hospital	From	To	Field
		City and State		
<b>Graduate School</b>	College(s)	From	To	Degree
	Field(s)			

Membership in Honorary or Professional Societies, prizes, awards, fellowships, ect. Please include AOA membership.

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**PROFESSIONAL GOALS AND CAREER PLANS** (Omit if included in CV or Personal Statement)

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<b>U.S. Board Certification or Eligibility</b>	Specialty	Certified or Eligible (circle one)	Date of Certification
	Specialty	Certified or Eligible (circle one)	Date of Certification

**MEDICAL LICENSURE:**

State \_\_\_\_\_ Year Issued \_\_\_\_\_

State \_\_\_\_\_ Year Issued \_\_\_\_\_

<b>Faculty Appointments</b>	College	From	To
	Department	Rank	
	College	From	To
	Department	Rank	

<b>Practice or Other Clinical Experiences</b>	Location	From	To
	Type		
	Location	From	To
	Type		

**PUBLICATIONS:** If applicable, please list publications on a separate sheet.

**TRANSCRIPT:** Please request the Registrar of your Medical College to send a transcript directly to the address at the top of the first page.

**REFERENCES:** Please list four references, of whom one must be the Dean of Students at your Medical College and three must be physicians who can render an evaluation of your professional and academic abilities. Please ask that your recommenders comment on academic and personal attributes such as judgment, industry, interpersonal relationships, capacity to assume responsibility and professional ethics. Please have these recommendations sent directly to the address at the top of the first page.

Dean of Students	Address
Other Recommenders	Address

I certify that to the best of my knowledge the above information is accurate and correct

Date \_\_\_\_\_

Signature \_\_\_\_\_

Please mail, email or fax the following items:

1. **APPLICATION**
2. **PASSPORT SIZE PHOTO**
3. **UPDATED CV**
4. **PERSONAL STATEMENT** (500 Words or Less)
5. **PUBLICATIONS:** If applicable, please list publications on a separate sheet.
6. **TRANSCRIPT:** Please request the registrar of your medical school to send a transcript directly to the address at the top of the first page.
7. **3 letters of REFERENCE:** Please **list** four references on the application, one of which must be the MSPE from the Dean of Students at your medical school and the other three letters must be from physicians who can render an evaluation of your professional and academic abilities (preferably from your residency program).
8. **Exam Scores**
9. If a graduate of a foreign medical school, have you obtained certification from the Educational commission for Foreign Medical Graduates? **(Proof)**

Indicate exams passed: ECFMG \_\_\_\_\_, Visa Qualifying Examination (VOE) \_\_\_\_\_, Foreign Medical Graduate Exam in the Medical Sciences (FMGEMS) \_\_\_\_\_, National Board Exam (parts 1-2-3)\_\_\_\_\_, United State Medical Licensing Examination (USMLE) (steps 1-2-3)\_\_\_\_\_, or FLEX \_\_\_\_\_.

Please use the following info to **mail, email or fax the contents of your application:**

Division of Cardiovascular Anesthesiology  
Texas Heart Institute at St. Luke's Episcopal Hospital  
c/o Nadia A. Ali & James Anton, MD  
P.O. Box 20345, MC 1-226  
Houston, TX 77225-0345  
Phone: 832-355-2202  
Fax: 832-355-6500  
E-mail: janton@heart.thi.tmc.edu

Please mail your **three letters of recommendation** written to the attention to:

Division of Cardiovascular Anesthesiology  
Texas Heart Institute at St. Luke's Episcopal Hospital  
c/o James M. Anton, M.D.  
Clinical Assistant Professor  
Fellowship Director  
P.O. Box 20345, MC 1-226  
Houston, TX 77225-0345