

Official Data Sheet and Application for Resident Physician

County of Los Angeles
Harbor-UCLA Medical Center



1. **Name** _____
Last First Middle

2. **Address** _____

3. **City, State, Zip** _____

4. **Phone** _____ **Social Security** _____

5. **Email Address** _____

6. **Birth date** _____ **Sex** _____ **U.S. Citizen?** _____

7. **Application is being made for** _____

(1st yr, 2nd yr, 3rd yr, etc.)

a. **Residency in** _____

8. **Undergraduate Training:**

a. **Name of School and Dates Attended** _____

9. **Medical School:**

a. **Name of School and Dates Attended** _____

10. **Degrees** _____ **Ethnic Origin** _____

11. **Residency Program** _____

12. **Starting Date** _____

13. **Projected Completion Date** _____

14. **Previous Residency Training** (if applicable):

1st year _____

	Dates Attended	Name of Hospital or School	Address
2 nd year	_____	_____	_____

3 rd year	_____	_____	_____
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4 th year	_____	_____	_____
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	Dates Attended	Name of Hospital or School	Address
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- 15. **California Medical License #** (if applicable) _____ **Exp Date** _____
- 16. **DEA # & Exp Date** _____
- 17. **Beeper #** _____ **Physician ID #** _____
- 18. **ACLS Certification** _____ **Exp Date** _____
- 19. **Visa Status/INS #** _____ **ECFMG Certificate** _____
- 20. **Marital Status** _____ **Spouse's Name** _____

Certificate of Applicant
(Read this statement carefully before signing)

I hereby certify that all statements made on or in connection with this application, are true and complete to the best of my knowledge and belief, and I understand and agree that any misstatements or omissions of material fact herein may cause forfeiture on my part of all rights of employment by the County of Los Angeles or by any district served by the County of Los Angeles Department of Human Resources.

Signature of Applicant Date

List any name(s) you have ever used other than the one signed above (maiden name, previous married name(s), etc.)
