



**University of Oklahoma
School of Community Medicine
Integrated Pre-Residency Application**

General Information

Program: Internal Medicine Family Medicine Pediatrics

Name:		
Address:		
City:	State:	Zip
Phone:	Alternate Phone:	
Email:		

Education

Undergraduate

Institution:	
Location:	
Major:	
Degree:	
Dates attended:	
Starting Month:	Starting Year:
End Month:	End Year:

Graduate

Institution:	
Location:	
Major:	
Degree:	
Dates attended:	
Starting Month:	Starting Year:
End Month:	End Year:

Medical Licensure/Examinations

Is there anything in your past history that would limit your ability to be licensed in the state of Oklahoma or to receive hospital privileges at the St. Francis, St. John, or Hillcrest Hospital systems?

Yes No

If yes, please give reason:

Do you have any current malpractice case(s) pending? Yes No

U.S. Medical Licensure Examination Step 1 Score:	1 st Attempt Y/N
U.S. Medical Licensure Examination Step 2 CK Score:	1 st Attempt Y/N

Other Information

Are you able to carry out the responsibilities of an Integrated Resident including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodation?

Yes No

Limiting Aspects:

Was your medical education interrupted?

Yes No

If yes, please give reason:

Medical School Honors/Awards: _____

Organizational Membership/Offices Held: _____

Research Experience(s)

Organization:	
Position:	
Description:	
Dates of experience:	
Starting Month:	Starting Year:
End Month:	End Year:

Organization:	
Position:	
Description:	
Dates of experience:	
Starting Month:	Starting Year:
End Month:	End Year:

Publications

Title:			
Authors:			
Publication:			
Month:	Year:	Volume:	Pages:

Title:			
Authors:			
Publication:			
Month:	Year:	Volume:	Pages:

Significant Volunteer/Work Experiences

Organization:	
Position:	
Description:	
Dates of experience:	
Starting Month:	Starting Year:
End Month:	End Year:

Organization:	
Position:	
Description:	
Dates of experience:	
Starting Month:	Starting Year:
End Month:	End Year:

Organization:	
Position:	
Description:	
Dates of experience:	
Starting Month:	Starting Year:
End Month:	End Year:

Organization:	
Position:	
Description:	
Dates of experience:	
Starting Month:	Starting Year:
End Month:	End Year:

Language Fluency (other than English): _____

Hobbies and Interests: _____

Other Accomplishments: _____

I certify that the above information listed in this application is correct.

Applicant Signature

Date

Please submit a completed application and a one page Personal Statement to Tammy (Tammy-Kuykendall@ouhsc.edu) or deliver in person to the SCM Student Services Office.

Please also have two Letters of Recommendation (One must be from an SCM Clerkship Director other than the program to which you are applying) submitted in person to SCM Student Services or emailed to Tammy(Tammy-Kuykendall@ouhsc.edu) .

Please list the two individuals who will be providing your Letters of Recommendation:

Letter writer 1:

Letter writer 2:

Please sign to waive your right to read or review your Letters of Recommendation:

Applicant Signature

Date