

Department of Surgery

**PA Surgical Residency**

Program Application

**Date of Application:**      

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| **Personal Data** | | | | | | | | | | |
| Name: Last | | First Middle | | | | | | | | |
| Mailing Address: Number and Street | | City, State & Zip Code | | | | | | | | |
| Home Phone | | Daytime Phone | | | | | | | | |
| Email Address | | | | | Cell Phone | | | | | |
| Permanent Address (if different) | | | | | Permanent Phone (if different) | | | | | |
| Date of Birth | | | | | Male | | | Female | | |
| **Education** | | | | | | | | | | |
| Institution: Include full name, location and any honors | | | Dates Attended | | | | Degree Conferred | | | |
| From  Mo/Yr | To  Mo/Yr | | | Type | | Date  Mo/Yr | |
| Undergraduate | | |  |  | | |  | |  | |
| Physician Assistant Program | | |  |  | | |  | |  | |
| Graduate work (doctoral or master) | | |  |  | | |  | |  | |
| Graduate work (doctoral or master) | | |  |  | | |  | |  | |
| **Other Clinical/Work Experience:** List chronologically your activities, if any, from the time of graduation from PA school *to the present*. | | | | | | | | | | |
| Type | Location | | | | | Dates | | | | |
| Type | Location | | | | | Dates | | | | |
| Type | Location | | | | | Dates | | | | |
| **Curriculum Vitae** | | | | | | | | | | |
| Please attach a current curriculum vitae with your fellowship application. | | | | | | | | | | |
| **Photograph** | | | | | | | | | | |
| Please attach passport size photograph with your application. | | | | | | | | | | |
| **Licenses or Certification** | | | | | | | | | | |
| Do you hold a current PA certification?  Yes  No If so, list expiration date here  Any other clinical licenses or certifications: List here | | | | | | | | | | |
| **Letters of Recommendation Requested**  At least three (3) letters of recommendation from faculty members/preceptors from your training program. One of these letters must be from the current or previous department head or training program director. List below the names and mailing addresses of your letter writers. Please ask your letter writers to send their letter to the address or the email on the last page. | | | | | | | | | | |
| 1. | | | | | | | | | | |
| 2. | | | | | | | | | | |
| 3. | | | | | | | | | | |
| Have you ever been convicted of a felony?  Yes  No If yes, please explain on a separate sheet of paper.  Will you require a VISA?  Yes  No | | | | | | | | | |  |
| Please sign your name and date below if you agree with the following statement:  *The information I have given in this application is current and complete to the best of my knowledge.*  Signature (your name here): Date: | | | | | | | | | |
| **Enclose with this Application**   * CV * Personal Statement * PA School Program diploma (if applicable) * PA School Program transcripts (if applicable) * Copy of PA Certification (if applicable) * Letter of good standing from Program Director if currently enrolled in a PA program | | | | | | | | | |
| For office use only:  Curriculum Vitae  Letters of recommendation  Photograph  Personal Statement  Other | | | | | | | | | |
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**RETURN COMPLETED APPLICATION WITH ENCLOSURES BY MAIL OR EMAIL TO:**

Lilas Nassour

University of Florida Department of Surgery

Surgery Education Office

University of Florida College of Medicine

PO Box 100287

Gainesville, FL 32610-0287

Email: Lilas.Nassour@surgery.ufl.edu

Fax: (352) 265-3292

For questions - Phone: (352) 265-0916