

APPLICATION FOR PREVENTIVE MEDICINE RESIDENCY PROGRAM (PMRP)

Please PRINT OR TYPE all responses, then sign and date on the next page. In addition, attach a typewritten Statement of Purpose (see item 22). For items 16-21, if your curriculum vitae (C.V.) contains the requested information, attach your C.V. and write "see attached C.V." in the blank space(s).

1. Name: Last _____ First _____ Middle _____

2. Address (street, city, state, ZIP) _____

3. Telephone
 Work: ()
 Home: ()

4. Birth date

 Month Day Year

5. Are you a U.S. citizen?
 Yes
 No

6. If non-U.S. citizen, specify citizenship and type of visa.

Email: _____

7. Legal Resident of California?
 Yes No

8. Are you licensed to practice medicine in California? (REQUIREMENT)
 Yes No
 If Yes: License Number: _____ Expiration: _____

9. In what other states are you licensed? (Include license number and expiration)

10. If you are certified by a specialty board:
 indicate specialty: _____
 date of certification: _____ and certificate number: _____

11. Please rate the following possible geographic locations for your residency placement using the following scale:
 0=not acceptable, 1=acceptable but not preferred, 2=preferred
 Southern CA ___ Central Valley ___ S. F. Bay Area ___ Sacramento Area ___ Northern CA ___

12. Applying for:
 Academic & Practicum
 Practicum Year Only

13. If academic year, also applying to:
 UC Berkeley UCLA UC Davis

14. Are you applying for a residency stipend?
 Yes No

15. EDUCATION, INTERNSHIPS, RESIDENCIES. Have official transcripts of your graduate (post-baccalaureate) education mailed to the program at the address on the next page. Summarize your undergraduate education, graduate education, internships, and residencies here. Attach additional pages or a C.V. if necessary.

Names and Locations of Schools or Institutions Attended	When Matriculated	Major	Diploma or Degree	Date of Completions

16. EXPERIENCE RECORD: List chronologically all experience in medicine, public health, or related fields excluding internship and residencies (but including periods of private practice and military service). The earliest employment should appear first. Attach additional pages or a C.V. if necessary.

Dates		Name and Address (City, State) of Employer	Description of Duties or Position
From	To		

Name: _____

17. Membership in professional or honorary associations:	18. Honors, prizes, awards:
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19. Publications:

20. REFERENCES. Request that three persons, including at least one physician, send a letter of recommendation to the Program at the address below. List your references here:

Name	Occupation and Title	Institution /Telephone/E-mail
(1)		
(2)		
(3)		

21. STATEMENT OF PURPOSE: Please attach one typed page giving your reasons for wanting to undertake training provided by this preventive medicine residency program. **THE PREVENTIVE MEDICINE RESIDENCY ADVISORY COMMITTEE OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH CONSIDERS THIS TO BE A CRUCIAL PART OF YOUR APPLICATION.** Include your future professional plans and any other information which may be helpful to the Committee.

22. Note: An interview is required before a final decision can be made. After your application has been reviewed, we will notify you if you are eligible for an interview.

NOTICE TO APPLICANTS:

The information requested on this form is required by the State Department of Public Health in order to determine your eligibility for acceptance into the Department's Preventive Medicine Residency Program. The information will also be used by the Department's Preventive Medicine Advisory Committee to select candidates for inclusion into the residency training program. Participation in this residency program is voluntary. If you choose to participate, you are required to provide information on these forms. If you do not provide this information, admission into the residency program may be denied.

Any information that you provide may be used by the State Department of Public Health or transferred to the Department of Public Health's Preventive Medicine Advisory Committee and institutions formally participating in the residency training program. Candidates and authorized personnel directly involved in the selection process will be allowed access. If you wish to review these records, contact Kathleen H. Acree, M.D., M.P.H., at the address below. After reviewing your records, you may request in writing that they be corrected or amended to make them accurate, relevant, and complete. Any request for correction or amendment should also be sent to Dr. Acree.

I certify that the information I have provided in my application is correct, and that I have read the above "Notice to Applicants."

Signature _____
Date

Please mail this application form with any attachments to:

For FedEx, UPS, or other courier:

Program Coordinator
 Preventive Medicine Residency Program
 California Department of Public Health
 MS-7213
 P.O. Box 997377
 Sacramento, CA 95899-7377

Program Coordinator
 Preventive Medicine Residency Program
 California Department of Public Health
 MS-7213
 1616 Capitol Avenue, Suite 74.420
 Sacramento, CA 95814

In addition, please have official transcripts and letters of recommendation mailed directly to the appropriate address above. If you have any questions, please telephone the Program Coordinator at (916) 552-9920 or e-mail CDPH-PDS@cdph.ca.gov. Thank you.