

**Northern Light EMMC Osteopathic Neuromusculoskeletal Medicine 3  
Residency Application**

**Personal Information**

Full Name	Preferred Name	Birthdate
Gender F=female, M=male)	SSN	
AOA Number	Birthplace	
Select Citizenship Type (dropdown box) Choose an Item	Select Visa Type (dropdown box) Choose an item.	Self-Identification

**Contact Address**

Street Address	City	State
Zip Code      Country	Contact Phone	Alternate Phone
Contact Email		

**Home / Alternate Address**

Street Address	City	State
Zip Code      Country	Contact Phone	Alternate Phone

**Military Obligation**

Are you committed to fulfill a U.S. Military active duty service obligation? (Y = Yes, N = No)  
If YES, Years of Commitment      Start Month      Start Year

**Non-Medical Undergraduate Education**

Please enter your two most recent undergraduate institutions you have attended.

#1  
Institution      City, State, Country

Major      Degree      Degree Date (month/year)

Dates of Attendance  
From (month/year)      To (month/year)

#2  
Institution      City, State, Country

Major      Degree      Degree Date (month/year)

Dates of Attendance  
From (month/year)      To (month/year)

Check here if you attended more than two non-medical undergraduate institutions.

**Non-Medical Graduate Education**

Please enter your two most recent undergraduate institutions you have attended.

#1  
 Institution City, State, Country  
 Major Degree Degree Date (month/year)  
 Dates of Attendance  
 From (month/year) To (month/year)

#2  
 Institution City, State, Country  
 Major Degree Degree Date (month/year)  
 Dates of Attendance  
 From (month/year) To (month/year)

Check here if you attended more than two non-medical graduate institutions.

**Undergraduate Medical Education**

For each undergraduate institution you have attended, please provide the following information.

#1  
 Institution City, State, Country  
 Major Degree Degree Date (month/year)  
 Dates of Attendance  
 From (month/year) To (month/year)

#2  
 Institution City, State, Country  
 Major Degree Degree Date (month/year)  
 Dates of Attendance  
 From (month/year) To (month/year)

Check here if you attended more than two medical undergraduate institutions.

**Residencies/Fellowships**

For each internship or residency position you have held, please provide the following information.

None

#1  
 Specialty Institution / Program  
 City State / Province Country  
 Program Director Supervisor  
 Years Dates of Residency  
 From (month / year) To (month / year)

#2  
Specialty Institution / Program  
City State / Province Country  
Program Director Supervisor  
Years Dates of Residency  
From (month / year) To (month / year)

Check here if you attended more than two residency programs.

**Osteopathic Manipulative Medicine Experience**

Attended an AOA approved residency

Yes  No

Attended an ACGME approved residency within the Osteopathic Recognition track

Yes  No

Number of OMM/OMT patients seen during residency

If currently in practice, how many OMM patients seen per month?

**Basic Cranial Course**

What year did you complete a basic cranial course and with what organization?

Osteopathic CME's attended in the past 3 years

**Work Experience**

For each work experience position you have had, please provide the following information.

None

#1

Organization Position

Description

If no, the reason for leaving

Dates of Experience: From (month/year) To (month/year)

#2

Organization Position

Description

Dates of Experience: From (month/year) To (month/year)

Check here if you have held more than two work positions

**Leadership, Extra-Curricular, and Volunteer Experiences**

For each experience you have had, please provide the following information.

None

#1

Organization Position

Description

Dates of Experience: From (month/year) To (month/year)

#2

Organization Position

Description

If no, the reason for leaving

Dates of Experience: From (month/year) To (month/year)

### Research Experience

For each experience you have had, please provide the following information.

None

#1

Organization Position

Description

If no, the reason for leaving

Dates of Experience: From (month/year) To (month/year)

#2

Organization Position

Description

If no, the reason for leaving

Dates of Experience: From (month/year) To (month/year)

### Publications

(Use also for Poster Sessions/Abstracts/Invited National or Regional Presentations). For each publication/presentation you have had, please provide the following information.

None

#1

Publication/Presentation Citation:

#2

Publication/Presentation Citation:

Check here if you have had more than two published articles and presentations.

### Medical Licensure

Current Medical Licensure (dropdown box)

Choose an item.

Has your medical license ever been suspended/revoked/voluntarily terminated? (Y = Yes, N = No)

If YES, please provide explanation:

Have you ever been names in a malpractice case? (Y = Yes, N = No)

If YES, please provide explanation:

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?  
(Y = Yes, N = No)

If YES, please provide explanation:

Have you ever had a Misdemeanor Conviction in the United States?

Have you ever had a Felony Conviction in the United States?

If YES, please provide an explanation

COMLEX I	COMPLEX II	COMPLEX III
<input type="checkbox"/> Score: <input type="checkbox"/> Passed on: <input type="checkbox"/> Failed on: <input type="checkbox"/> Awaiting results from: <input type="checkbox"/> Will take on: <input type="checkbox"/> Will retake on:	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on: <input type="checkbox"/> Failed on: <input type="checkbox"/> Awaiting results from: <input type="checkbox"/> Will take on: <input type="checkbox"/> Will retake on:	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on: <input type="checkbox"/> Failed on: <input type="checkbox"/> Awaiting results from: <input type="checkbox"/> Will take on: <input type="checkbox"/> Will retake on:

USMLE I	USMLE II	USMLE III
<input type="checkbox"/> Score: <input type="checkbox"/> Passed on: <input type="checkbox"/> Failed on: <input type="checkbox"/> Awaiting results from: <input type="checkbox"/> Will take on: <input type="checkbox"/> Will retake on:	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on: <input type="checkbox"/> Failed on: <input type="checkbox"/> Awaiting results from: <input type="checkbox"/> Will take on: <input type="checkbox"/> Will retake on:	<input type="checkbox"/> Score: <input type="checkbox"/> Passed on: <input type="checkbox"/> Failed on: <input type="checkbox"/> Awaiting results from: <input type="checkbox"/> Will take on: <input type="checkbox"/> Will retake on:

Are you Board Certified? Yes

No

Specialty Board

Initial Certification Date

Expiration Date

Please have your Residency Coordinator or the NBOME forward your scores to [mpelkey@northernlight.org](mailto:mpelkey@northernlight.org)

### All Applicants

Are you able to carry out the responsibilities of an ONMM3 resident at our training program including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?

- Yes  
 No  
 No Response

Limiting Aspects:

Was your medical education extended or interrupted? If YES please provide an explanation below

- Yes  
 No

Explanation

### Personal Statement

Please provide us with a personal statement that could include hobbies and interests, other awards and accomplishments, personal strengths, reasons for interest in our hospital and this specialty.

I have reviewed and completed this application training form for the Northern Light EMMC ONMM3 Residency. By submitting this form, I attest that the information I have provided on this form is true and accurate to the best of my knowledge. I understand that the program may seek proof or verification from me or third parties of the information I have provided on this form. I further understand and acknowledge that providing false information on this form is unethical and would constitute cause for my immediate termination from the training program.