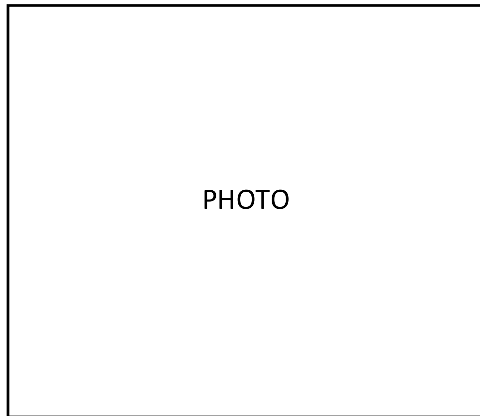
Please return application materials to:
OhioHealth O'Bleness Hospital attn: Graduate Medical Education 55 Hospital Drive Athens, OH 45701 T: 740-592-9334 OBH-MedicalEducation@ohiohealth.com

OhioHealth O'Bleness Hospital Osteopathic Neuromusculoskeletal Medicine Residency

We consider applicants for all positions without regard to race, color, religion, gender, national origin, marital or veteran status, disability, or any other legally protected status. OhioHealth will consider applicants who are U.S. citizens, lawful permanent residents, asylees and refugees, and other individuals with work authorizations that do not require visa sponsorship by the hospital.



Application for academic year: 20________- 20 __________

____
Name

____
Other name(s) used

____
Address

____

____
City **State** **Zip**

Email: ___________________________ **Cell Phone:** ____________________

Do you have a military obligation following your residency? YES NO Branch _______________

Do you have a public health obligation following your training? YES NO

Do you have or have you ever had a physical or mental condition (including drug or alcohol abuse) that could affect your ability to exercise the activities associated with this affiliation or would require reasonable accommodations in order for you to perform activities requested in a safe and competent manner? YES NO *If yes, provide information on a separate sheet.*

CERTIFICATION OF INFORMATION
Signature and date on this application must be original.

I certify that to the best of my knowledge all of the information provided herein is true, accurate and complete. I further understand that any omission or misrepresentation of the facts contained in this application will be grounds for a denial of my application, the withdrawal of any offer of an appointment, or automatic dismissal from the program. I further understand that a serious omission of misrepresentation of the facts contained herein may lead to the initiation of civil or criminal proceedings against me under all applicable federal and state laws.

____ ____________________________________
Signature **Date**

EDUCATIONAL BACKGROUND:

Type of School	Name of School and Complete Mailing Address	Years Completed	Major or Degree
Undergraduate		From: To:	
Medical School		From: To:	
Other		From: To:	

RESIDENCY:

Residency Program Name	
Complete Address	
Program Phone Number	
Program Director Name	
Dates of Training	From: To:
Specialty	
Program Complete?	___Yes ___No
If no, please explain:	
Residency Program Name	
Complete Address	
Program Phone Number	
Program Director Name	
Dates of Training	From: To:
Specialty	
Program Complete?	___Yes ___No
	If no, please explain:
Did you have any interruptions in your medical training?	___Yes ___No
If yes, please explain:	

ONMM and OPP Conferences attended:

Name	Date	Attended/Presented

Cranial Course:

Sponsoring Organization	Date Attended

NMM/OMM/ONMM Rotations: (indicate n/a if not completed)

Type	Date	Location	Instructor
Inpt Consult Service			
Sports Medicine			
Pediatric Medicine			
Orthopedic Surgery			
Neurological Surgery			
Neurology			
Occupational Medicine			
Rheumatology			
PM&R			
Musculoskeletal Radiology			
Pain Management			
Radiology			
Other - please indicate			

Previous Employment, including Previous Practice Experience:

Name of Employer or Practice	
Full Address of Employer	
Name of Supervisor	
Supervisor Phone Number	
Dates of Employment	
Last Job Title	
Job Duties	
Reason for Leaving	
Name of Employer or Practice	
Full Address of Employer	
Name of Supervisor	
Supervisor Phone Number	
Dates of Employment	
Last Job Title	
Job Duties	
Reason for Leaving	

REFERENCES

Please have your references mail letters of recommendation directly to:

OhioHealth O'Bleness Hospital
Attn: Graduate Medical Education
55 Hospital Drive, Athens, OH 45701
or to OBH-MedicalEducation@ohiohealth.com

Residency Program Director

1. Name: ____

   Institution: ____

   Address: ____

   ____
   City State Zip

   Phone: ________________________________
   Email: ________________________________

Osteopathic Physicians

2. Name: ____

   Address: ____

   ____
   City State Zip

   Phone: ________________________________
   Email: ________________________________

3. Name: ____

   Address: ____

   ____
   City State Zip

   Phone: ________________________________
   Email: ________________________________

4. Name: ____

   Address: ____

   ____
   City State Zip

   Phone: ________________________________
   Email: ________________________________

LICENSURE INFORMATION

Do you have or ever held a State of Ohio medical license and/or training certificate? YES NO License # ________________

State Licensure: ______________________________ Date Issued ________ License # ________________

State Licensure: ______________________________ Date Issued ________ License # ________________

Training Certificate: ____________________________ Date Issued ________ License # ________________

Training Certificate: ____________________________ Date Issued ________ License # ________________

PERSONAL

Have you ever engaged in private practice? YES NO Location: ________________

Have you ever failed to complete or have been mutually released from another training program? YES NO *If yes, provide information on a separate sheet.*

Are there any actions or proceedings which have involved the suspension or revocation of your license or limited permit in any state or jurisdiction? YES NO *If yes, provide information on a separate sheet.*

Citizenship:

	U.S.	Name of Country
	Other	

Status:

	Permanent Resident	Alien #
	J-1 Visa	
	H-1 Visa	

Self-Identification:	
	American Indian or Alaskan Native
	Asian (please specify)
	Black or African American
	Hispanic, Latino or of Spanish Origin
	Native Hawaiian or Pacific Islander
	White
	Other (please specify)
	Prefer not to say

Return completed application to:

OhioHealth O'Bleness Hospital
Attn: Graduate Medical Education **-OR-** **email application to: OBH-MedicalEducation@ohiohealth.com**
55 Hospital Dr.
Athens, OH 45701