

**SF MATCH**  
**Central Application Service**  
**Plastic Surgery Residency**

Name: \_\_\_\_\_

Registration #: [ ] [ ] [ ] [ ] [ ]

**PERSONAL DATA**

Name (Last, First, Middle)

Address where you can best be reached:

Day Phone:

Evening Phone:

Email:

Alternative/Permanent address:

Day Phone:

Evening Phone:

Email:

Are you a U.S. Citizen?

Yes  No

Visa Status (if applicable):

Permanent  J-1  H-1  Other \_\_\_\_\_

Do you have military service obligations?

Yes  No

**PREREQUISITES**

*I have passed the following examinations:*

**USMLE Step 1:**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3 digit score: \_\_\_\_ 2-digit score: \_\_\_\_ Number of times taken: \_\_\_\_

**USMLE Step 2 CK:**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3 digit score: \_\_\_\_ 2-digit score: \_\_\_\_ Number of times taken: \_\_\_\_

**USMLE Step 3:**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3 digit score: \_\_\_\_ 2-digit score: \_\_\_\_ Number of times taken: \_\_\_\_

I expect to take the USMLE Step 3 exam in \_\_\_\_/\_\_\_\_/\_\_\_\_ and should receive my score in \_\_\_\_/\_\_\_\_/\_\_\_\_

IN SERVICE SCORES	Year 1	Year 2	Year 3	Year 4	Year 5
Score					
Percentile					

*I have previously passed the following exam(s) which are still valid:*

NBME  ECFMG  FLEX  VQE  COMLEX  OTHER: \_\_\_\_\_

*I am licensed in the States of:*

ECFMG registration number (if applicable): \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_

**SF MATCH**  
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**EDUCATION**

List your college, medical school and graduate level experience in chronological order (most recent first)

School/Medical Facility/Institution	Major/Specialty	Dates Attended From (mo/yr) to (mo/yr)	Degree / Date Granted	GPA (if noted on transcript)

Medical School Class Rank (if available): \_\_\_\_\_ or  Class rank not available

AOA Honor Society is available at my school:  No  Yes (If yes, check below):

I was elected as junior/senior  I was not selected for AOA

**TRAINING**

<b>INTERNSHIP</b> Program Name, City, State	Type of Internship	Dates Attended	Program Director
<b>RESIDENCY</b> Program Name, City, State	Type of Residency	Dates Attended	Program Director
<b>RESEARCH (If applicable)</b> Program Name, City, State	Dept/Division	Dates Attended	Mentor
<b>FELLOWSHIP (If applicable)</b> Program Name, City, State	Type of Fellowship	Dates Attended	Program Director

Please explain any gaps in training:

**SF MATCH**  
**Central Application Service**  
**Plastic Surgery Residency**

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Registration #: [ ] [ ] [ ] [ ] [ ]

**LETTERS OF REFERENCE**

Three letters of reference are required. One letter from your training program director is required. The other two letters should be from objective physicians (i.e. not relatives or family friends) who have a direct personal knowledge of your skills and ethics. Please indicate below the letters of reference that are part of your application.

**Letter of Reference #1**

Name and Title:

Institution:

Address:

Phone:

- I have waived access to this letter and have informed the author of this confidentiality.  
 I desire access to this above letter and have informed the author.

**Letter of Reference #2**

Name and Title:

Institution:

Address:

Phone:

- I have waived access to this letter and have informed the author of this confidentiality.  
 I desire access to this above letter and have informed the author.

**Letter of Reference #3**

Name and Title:

Institution:

Address:

Phone:

- I have waived access to this letter and have informed the author of this confidentiality.  
 I desire access to this above letter and have informed the author.

When you begin Plastic Surgery Residency will you have completed residency in General Surgery?  Yes  No

When you begin Plastic Surgery Residency will you have completed residency in another field?  Yes  No

If yes, indicate field: \_\_\_\_\_

When you begin Plastic Surgery Residency will you be board eligible for board certification in your prereq field?  Yes  No

If yes, indicate Board organization: \_\_\_\_\_

Have you ever been discharged/terminated/failed to have a contract renewed by a training program?  Yes  No

If yes, explain: \_\_\_\_\_

Have you ever resigned from a training program?  Yes  No

If yes, explain: \_\_\_\_\_

# SF MATCH

## Central Application Service Plastic Surgery Residency

Name: \_\_\_\_\_

Registration #: [ ] [ ] [ ] [ ] [ ]

*This section is to help selection committees achieve a better understanding of your experiences, motivations, interests and work preferences related to the specialty.*

### Past and Present Employment:

Employer	City and State	Dates Employed From (mo/yr) to (mo/yr)

### Public Service and Activities:

### Outside interests and hobbies:

SF MATCH

**Central Application Service  
Plastic Surgery Residency**

Name: \_\_\_\_\_

Registration #: [ ] [ ] [ ] [ ] [ ]

**Research Activities, papers and/or additional information:**

*List authors and complete reference in chronological order*

**Peer Review Publications:**

**Other publications:**

**Invited lectures:**

**SF MATCH**  
**Central Application Service**  
**Plastic Surgery Residency**

Name: \_\_\_\_\_

Registration #: [ ] [ ] [ ] [ ] [ ]

Other research activities/lectures:

Honors/awards/other achievements:

# SF MATCH

## Central Application Service Plastic Surgery Residency

Name: \_\_\_\_\_

Registration #: [ ] [ ] [ ] [ ] [ ]

**Have you ever been named in a malpractice suit?**

Yes  No (If yes, please explain below):

Name of Agency	Date	Circumstances	Final Action	Under Appeal? (Yes/No)

**Have you ever been convicted of or entered a plea of guilty or no contest to a crime (misdemeanor or felony)?**

Yes  No (If yes, please explain below):

Offence	Date	Jurisdiction	Final Action	Under Appeal? (Yes/No)

**Have you ever been charged with use of illegal substances or charged with criminal actions related to use of drugs or alcohol?**

Yes  No (If yes, please explain below):

Offence	Date	Jurisdiction	Final Action	Under Appeal? (Yes/No)

**COMMENTS:**

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**Central Application Service  
Plastic Surgery Residency**

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Registration #: [ ] [ ] [ ] [ ] [ ]

**PERSONAL STATEMENT**

*Please discuss who/what inspired you to enter plastic surgery as well as your career and life objectives.*

**SF MATCH**  
**Central Application Service**  
**Plastic Surgery Residency**

Name: \_\_\_\_\_

Registration #: [ ] [ ] [ ] [ ] [ ]

**PERSONAL STATEMENT** (Continued)

By checking this box, I certify that the information in this application is true and complete and that I have not withheld information that might significantly affect my qualifications for residency training. Applicants to the Plastic Surgery match must submit an application to the Federal Credentials Verification Service (FCVS) to establish "Physician Information Profile". The FCVS application is available online at <http://www.fsmb.org/fcvs.html>. I understand that any misrepresentation in this application and its accompanying documents may be cause for immediate termination of my application process or future employment. I authorize any training program that receives this application to contact any or all of my former employers, educational institutions and/or other persons or organizations who may have information relevant to my application. I understand that any information obtained will be treated as confidential information. I authorize SFMatch to use any information I have provided to SFMatch in any study approved by SFMatch, provided that no information clearly and uniquely identifiable with me is disclosed in reports resulting from such study. I intend to complete all prerequisites before the start of my residency training. I understand that any contract or match result will be void if I do not satisfactorily complete my prerequisite training or if I fail to meet other requirements that have been explicitly states to all applicants. I will formally withdraw from this match prior to the rank list due date if I accept any position outside the match before the due date. If I match through SFMatch, I will withdraw from all other competitive matches in post-graduate medicine.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_