DREXEL UNIVERSITY COLLEGE OF MEDICINE

In the Tradition of Woman's Medical College of Pennsylvania and Hahnemann Medical College™

Please indicate that you have attached the following to your application:

Refresher/Re-entry Application Packet must include:

Copy of your Medical Degree certificate (in English or English translation)

Transcripts from medical school (in English or English translation)

Copy of recent license (if applicable)

Curriculum vita

USMLE steps 1 and 2 score report

GME Residency Certification (if applicable)

ECFMG Certification (if applicable)

Head shot Photo

$50 Application Fee

DREXEL UNIVERSITY COLLEGE OF MEDICINE

In the Tradition of Woman's Medical College of Pennsylvania and Hahnemann Medical College™

Drexel Medicine® Physician Refresher/Re-Entry Course

Application - Structured Preceptorship

Name: ____
Last First Middle Initial M.D./D.O. Gender

Address: ____
Street Address/Apartment Number City State Zip Code

Home Phone: ( ) _____________ Work Phone ( ) _______________ E-Mail ____________________________________

Age *[gct"qh"Dktvj + ______________________ Place of Birth ____

Medical School _______________________________________ Location ___________________ Graduation Year ___________

Did you complete an internship? If yes, where __________________ Dates of internship from ______ to ______

Did you complete a residency? " "If yes, where ____________________ Dates of residency from ______ to ______

Name and location of hospital where residency was completed ____

When are you available to begin the onsite Preceptorship? The Preceptorship starts the first Monday of each month. Indicate three potential dates you are available to begin the course.

Month/Year _____________________ **Month/Year** _____________________ **Month/Year** _____________________

The Preceptorship is offered in 6 week blocks. Identify your preference. 6 Week Block 12 Week Block 18 Week Block

Residency Field ____ Years away from clinic practice ______________________

If applicable, write a summary describing why you are not currently practicing and what you have been doing since you left clinical practice ____

____

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____

The Preceptorship has tracks in OBGYN, Internal Medicine, Pediatrics and Surgery. Which is your first preference? ____________

The Preceptorship may be modified to meet special needs. Please identify any special needs.

____

What are the two most important things you hope to gain or your specific goals for the Preceptorship?

____

Primary Employer _________________________________ Current Position _______________________________________

Have you been convicted of a felony within the last ten years? Misdemeanor?

Has any disciplinary action ever been taken against your license to practice?

Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?

Has your DEA registration ever been denied, revoked or restricted?

****If you answered yes to any of the four questions above, additional information will be requested**0

Residency status? U.S. citizen Permanent Resident U.S. Visa If non US Citizen, Home Country________________

If in the US on a visa, what type of visa? __________________________________Date visa expires _________________________

What is your primary language? ____TOFEL Score (if applicable) ________________

USMLE score/date completed: Step 1 ___________________ Step 2 ______________________ Step 3 _____________________

ECFMG Certified Kf yes, date completed _______________________________

Are you licensed to practice in the U.S.? "" If yes, what state ______________________________

Are you licensed to practice outside of the U.S.? """""""""""" If yes, what country(s) ____________________________

Do you have a Pennsylvania Medical Training License?

Are you board certified (or its equivalent) in a specialty? """"""""""""""""""""""""""""""""""If so, what specialty? _________________________

Do you have medical malpractice insurance that provides coverage in the US? "" If yes, submit top cover sheet of the policy.

Will you have personal health insurance during participation in the Preceptorship?

Will you need assistance finding housing for the duration of the program?

How were you referred to this program ? ____

If a report is required at the end of the course, who will receive the report ____________________, Due Date ______________

Return with a copy of your medical degree, transcript (in English or English translation), recent license, your curriculum vita, USMLE Uvgr 'Kcpf " KK'ucores'reports, a copy of your GME certification (if applicable), a copy of ECFMG (if applicable), head shot photo and $50 application fee.

If paying application fee by credit card:

Credit Card type	Credit Card Number	Expiration Date	Signature

(Do Not E-Mail application with credit card information)

Forward application by mail or fax to:
Drexel University College of Medicine
Office of Continuing Medical Education
1427 Vine Street Room 405, Mail Stop 1013
Philadelphia, PA 19102 Phone # 215-762-2580 Fax # 215-762-2589

Applicants must submit to a background check. Following a preliminary review of your application, we will require your authorization to conduct a background check. A processing fee may be required. Once accepted into the program, you will be asked to submit to DUCOM and Hahnemann University Hospital health screening requirements: including a drug screening and recent PPD and vaccine titers test (measles, mumps, rubella, varicella and Hepatitis B). ***The results may be requested prior to the start of the program.*** **See health screening requirements under the link for "Prospective Students".**

Before the final admissions decision, you may be contacted by telephone to review your application and discuss your training priorities.

****************************Do not write below this line ********************************

ADMISSION DECISION

☐ Admitted ☐ Denied Start Date ______________________________

Signature/date : ______________________________

Comments : ______________________________

Assigned Department/Division/Speciality ______________________________

Assigned Preceptor: ______________________________