

**TULANE UNIVERSITY SCHOOL OF MEDICINE**  
**RESIDENT/FELLOW DATABASE FOR GRADUATE MEDICAL EDUCATION**

*Please print clearly!*

SOCIAL SECURITY (U.S.) # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_

Circle One: M.D. / D.O.

MEDICAL SCHOOL OF GRADUATION \_\_\_\_\_  
(Full name of school)

If U.S. Graduate: \_\_\_\_\_  
City State

If International Graduate: \_\_\_\_\_  
City Country

DEGREE RECEIVED: \_\_\_\_\_ DATE GRADUATED: \_\_\_\_\_ / \_\_\_\_\_  
(M.D., D.O., etc.) (Month / Year)

DEPARTMENT or SECTION \_\_\_\_\_ HO LEVEL \_\_\_\_\_

Circle One: Resident / Fellow

LOUISIANA MEDICAL LICENSE STATUS: \_\_\_\_\_  
Number Expiration Date

PLACE OF BIRTH \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SEX \_\_\_\_\_  
(City & State/Country) MM DD YY

RACE (*check one box below*):

- WHITE, not of Hispanic origin. A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- BLACK, not of Hispanic origin. A person having origins in any of the black racial groups of *Africa*.
- HISPANIC. A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
- ASIAN-AMERICAN, Asian or Pacific Islander. A person having origins in any of the original peoples of the Far East, Southeast Asia, *the Indian Subcontinent*, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.
- AMERICAN-INDIAN, American Indian or Alaskan Native. A person having origins in any of the original peoples of North America, *and who maintains cultural identification through tribal affiliations or community recognition*.

CITIZENSHIP: \_\_\_\_\_ VISA STATUS: \_\_\_\_\_  
Country Type and expiration date

\_\_\_\_\_  
NAME (LAST, FIRST)

LOCAL (*New Orleans*) ADDRESS:

\_\_\_\_\_  
\_\_\_\_\_

LOCAL (*Home*) PHONE NUMBER:

\_\_\_\_\_

PERMANENT ADDRESS:

\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU HAD ANY PRIOR RESIDENCY OR FELLOWSHIP TRAINING? YES \_\_\_\_\_ NO \_\_\_\_\_**

**IF SO, PLEASE LIST THE TYPE OF PROGRAM & DATES OF TRAINING:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IMMUNIZATION STATUS (Give Date of Vaccination or Childhood Illness):

Hepatitis B 1. \_\_\_\_/\_\_\_\_/\_\_\_\_ 2. \_\_\_\_/\_\_\_\_/\_\_\_\_ 3. \_\_\_\_/\_\_\_\_/\_\_\_\_

Mumps/Measles/Rubella \_\_\_\_/\_\_\_\_/\_\_\_\_ Chicken Pox \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last TB Skin Test \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Positive / Negative BCG \_\_\_\_\_

Do you have any medical conditions or allergies of which we should be aware?

\_\_\_\_\_

PLEASE ATTACH  
PHOTO HERE

I certify that all of the above information  
is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Resident Physician

\_\_\_\_\_  
Date Signed