EMORY HEALTHCARE

EMORY UNIVERSITY

Physician Assistant Post-Graduate Residency Program in Urology - *Application*

For Start in Spring ____ or Fall ____ of Year _____. Have you applied to our program in past? ☐ Yes ☐ No

Contact Information

Name_____
LAST First Middle

Maiden name or other names used in the past _____

Current address _____

City, State and Zip code _____

Telephone Cell: _____ Home: _____ Other: _____

Address _____

City, State and Zip code _____

Email address _____

Date of Birth _____ Sex: ☐ M ☐ F Social Security Number _____

Education

PA Program Attended/Attending _____

Graduation Month/Year _____ Degree _____

NCCPA Certification Date _____ Certification Number _____

If NCCPA Certification Pending, when are you eligible to sit for PANCE? _____

Graduate School / Location _____

Graduation Year _____ Degree _____ Major _____

Undergraduate School / Location _____

Graduation Year _____ Degree _____ Major _____

Undergraduate School / Location _____

Graduation Year _____ Degree _____ Major _____

Are you currently licensed as a PA? ☐ Yes ☐ No If yes, in what State(s)? _____

Have you ever had your professional license suspended or revoked? ☐ Yes ☐ No
If yes, explain _____

Were you ever required to leave school or denied readmission for disciplinary or academic reasons? ☐ Yes ☐ No
If yes, explain _____

Have you ever been convicted of a felony in any state? ☐ Yes ☐ No

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Medical Experience *(You may attach a curriculum vitae / resume)*

Position _____ City, State _____ Dates _____

Brief description of duties _____

_____

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Brief description of duties _____

_____

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Brief description of duties _____

_____

Position _____ City, State _____ Dates _____

Brief description of duties _____

_____

Other Certifications / Dates

Applicant Evaluations to be submitted by the following:

Name / Title	Email	Telephone

Personal Statement

Please attach a one-page statement to explain your interest, your expectation from the post-graduate urology residency program, and how your life experiences have prepared you for this endeavor.

I certify that the information in this application is complete and correct to the best of my knowledge.

_____ _____

Signature Date

Please Return application to: **Physician Assistant Residency Program**
Emory Department of Urology
1365 Clifton Rd NE, Suite 1400 B
Atlanta, Georgia 30322

Phone: (404) 778-4697
Fax: (404) 778-4336