UCLA Department of Family Medicine
International Medical Graduate (IMG) Program
David Geffen School of Medicine
Application

PROGRAM ELIGIBILITY:

UCLA INTERNATIONAL MEDICAL GRADUATE PROGRAM: ELIGIBILITY AT A GLANCE			
STATUS	**YES**	**NO**	**COMMENTS**
U.S. Citizen or Permanent Resident	☐	☐	**If NO, please STOP as you do not meet criteria.**
Is your medical school(s) listed on the Medical Board of California (MBC) website: http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx	☐	☐	**If NO, please STOP as you do not meet criteria**
Resided and/or studied a minimum of 6 years in a Latin American country	☐	☐	**If NO, please STOP as you do not meet criteria**
Did you **FAIL** USMLE Step exams more than once?	☐	☐	**If YES, please STOP as you do not meet criteria**
IF APPLICABLE, Did you complete a residency training program outside of the U.S.?	☐	☐	**If Yes, please provide specialty: _____**

Note: This application should only be completed by those who meet eligibility.

Please check the appropriate program:-

☐ **Program A (USMLE Step 1)** ☐ **Program B (USMLE Step 2CS &CK)** ☐ **Program C (USMLE Step 3)**

INSTRUCTIONS: Type or Print

Your application will be considered complete once all of the items on the checklist (on page 7) are received.

1. PERSONAL DATA

(*Personal Data, including your gender and ethnicity, will remain confidential and will only be used to satisfy reporting requirements set by program funding agencies.)*

_____ _____ _____

Last Name **First** **Middle**

_____ _____

Permanent Resident I.D. Number

_____ **How long in the U.S. (Months)**_____ **U.S. Citizen** ☐ **Yes** ☐ **No**

Country of birth

Birth Date: _____ **Visa Type/No:** _____

Gender: ☐ **M** ☐ **F** **E-mail Address:** _____

_____

CURRENT Address (if different than Permanent Address) **Apt. No.**

_____

City **State** **Zip Code**

_____

PERMANENT Address **Apt. No.**

_____

City **State** **Zip Code**

Current Telephone:_____**Permanent Telephone:**_____**Cell Phone:**_____

Ethnicity: _____
[American Indian (AI) / Asian/Pacific-Islander (A/PI) / Black (B) / Hispanic (H) / White (W)]

Applicant's first spoken language:

- ☐ English only
- ☐ Spanish only
- ☐ English & Spanish
- ☐ Other non-English specify: _____

2. EMERGENCY CONTACT

_____ _____
Last Name First Middle Relationship

Home Phone: _____ **Work Phone:** _____ **Cell Phone**: _____

NO____

3. EDUCATIONAL DATA: Please Submit Copies of Official Transcripts

List all colleges, graduate and professional schools attended.

3.1 Does your medical school appear as a recognized school by the Medical Board of California?
(You can check the Medical Board of California website http://www.medbd.ca.gov/applicant/schools.html)
YES ☐

Institution	Location City/State/Country	Dates of Attendance (mm/yyyy – mm/yyyy)	Major/Area of Focus	Date of Graduation Date Degree Granted (mm/yyyy)	GPA at Graduation Provide scale (e.g. 8/10)
Medical School:					
Social Service:					
Residency Training: (Specialty)					
Other Graduate School:					
Other:					

3.2 Do you have any gaps or interruptions in attendance while you were in medical school? If so, what year and for how long and what was the reason for the interruption in attending medical school?

3.3 TIMELINE OF ALL ACTIVITIES from year of graduation to present; explain any gaps!!!

Beginning from your year of graduation to present, please provide a timeline of activities including, location, month, and year of activity**. Please complete a sample Timeline of Activities from the Medical Board of California. http://www.mbc.ca.gov/Forms/Applicants/timeline_activities.pdf**

3.4 Medical Board of California: Post Graduate Training Authorization Letter (PTAL) or the California Letter is a requirement to begin a residency training program in California.

The Medical Board of California requires 1,152 hours (or 36 weeks) of direct, hands-on clinical practice experience during medical school in the following clinical subjects:

Surgery: 256 hours or 8 weeks
Medicine: 256 hours or 8 weeks
Pediatrics: 192 hours or 6 weeks
Ob-Gyn: 192 hours or 6 weeks
Family Medicine: 128 hours or 4 weeks
Psychiatry: 128 hours or 4 weeks

Please complete an unofficial sample, L5 worksheet from the Medical Board of California and attatch to your application: http://www.mbc.ca.gov/Forms/Applicants/application_ptal.pdf.

4. USMLE TEST RESULTS

How many times have you taken the following examinations? Please submit copies of ALL test results - including FAILS.

USMLE 1 _____ **time(s)** _____ **Score(s)** _____ **Date(s)**

USMLE 2CK _____ **time(s)** _____ **Score(s)** _____ **Date(s)**

USMLE 2CS _____ **time(s)** _____ **Score(s)** _____ **Date(s)**

USMLE 3 _____ **time(s)** _____ **Score(s)** _____ **Date(s**

5. USMLE Test Prep information?

(Please check all that may apply)

- ☐ Kaplan
- ☐ Princeton Review
- ☐ Pre-Prep Basic Science Review- Dr. Cazal
- ☐ Other: _____

6. FAMILY DATA

	EDUCATIONAL BACKGROUND Highest level completed	**OCCUPATION**
Father		
Mother		
Spouse/Significant other		

Number of children, if any: _____

6.1 Socio Economic Background (Please type replies on a separate document)

1. Describe any specific difficulties in your life. Include how you dealt with them and their influence upon your personal development.

2. How did you finance your medical school education?

7. MEDICAL PRACTICE HISTORY (after medical school)

Employer	**Location City/State /Country**	**Address & Contact Information**	**Dates of Practice mm/yy – mm/yr**	**Reason for Leaving**

8. EMPLOYMENT HISTORY

Present Employment Status:

- ☐ Employed full-time
- ☐ Employed part-time (_____hours/week)
- ☐ Not currently employed

Please list all employment for the past 3 years starting with most current:

Employer/Supervisor	Location City/State/Country	Address & Contact Information	Job Title	Start/End Date mm/yy-mm/yy	Reason for Leaving

9. STATEMENT OF INTENT

Please attach a typed 2-3 page concise statement of intent addressing the following:

- Why did you study medicine?
- For any period of time, did you experience an interruption during medical school? If yes, please explain.
- What did you learn in medical school?
- Your knowledge in the field of Family Medicine.
- Describe your experience in Family Medicine (including your medical school's orientation to Family Medicine, your clerkships in Family or Community Medicine, or any extra-curricular experiences in Family Medicine).
- Skills you possess that a family physician would value.
- What factors contributed to you immigrating to the US?
- What do you hope to achieve in a Family Medicine residency?
- Your personal and professional goals.
- Upon completion of this program and a Family Medicine residency, describe where you would likely work and the type of patient population you would serve.
- Do you have any sources of income that can help sustain you during the program?

10. LETTERS OF RECOMMENDATION

Please submit two letters of recommendation from an instructor, academic advisor or employer.

11. APPLICATION DEADLINES

Applications for all programs are accepted throughout the year. Finalists will be notified via email and granted an interview with the program.

12. APPLICATION CHECKLIST:

- ☐ Completed and signed application form with copies of official medical school transcripts (If applicable, residency transcripts)
- ☐ Copy of Social Security Card (If selected, at time of interview)
- ☐ Copy of Permanent Resident ID card and Visa (If selected, at time of interview)
- ☐ Copy of degree/diploma (if not issued, when do you expect to receive it _____) both in Spanish and English (Please refer to Medical Board of California PTAL section on approved "Translation of foreign academic credentials")
- ☐ Copy of USMLE Step 1 score reports (All passed & failed scores)
- ☐ Copy of USMLE Step 2 CK score reports (All passed & failed scores)
- ☐ Copy of USMLE Step 2 CS score reports (All passed & failed scores)
- ☐ Copy of USMLE Step 3 score reports (All passed & failed scores)
- ☐ Offical USMLE Transcripts.
- ☐ Copy of PTAL "California Letter" (Program C applicants, if available)
- ☐ Copy of ECFMG Certification (Program C applicants, if available)
- ☐ Completed sample L5 form
- ☐ Completed socio economic background
- ☐ Completed statement of intent
- ☐ Wallet/passport size photo attached to an index card which contains your full name, email address, current and permanent address, telephone numbers as well as emergency contact address and telephone numbers.
- ☐ Two letters of recommendation
- ☐ If applicable, name of Medical Board of California analyst

13. INSTRUCTIONS:

1. Please submit completed applications to **fmimgprogram@mednet.ucla.edu**. After submitting the application form online, please mail completed application package: copies of your official medical school transcripts, medical school degrees, and permanent residency card along with all USMLE pass and fail attempts and a check money order for $75.00 *payable* to "UC Regents".

2. **Please mail COMPLETED Application Package to:**

   UCLA International Medical Graduate Program
   1920 Colorado Ave. 2nd Floor
   Santa Monica, CA 90404
   Email all inquiries to: fmimgprogram@mednet.ucla.edu

The program advisory panel will review the application and notify applicants whether they have been selected to *interview*. Each applicant will receive notification of the panel's decision.

14. ATTESTATION OF ACCURACY AND PARTICIPATION

Please initial	
	I certify that the above information is true and correct. I agree to provide, if requested, any official documentation necessary to verify this information. I understand that false statements or misrepresentation on this form may result in cancellation of admission to the UCLA Department of Family Medicine International Medical Graduate (IMG) Program – David Geffen School of Medicine at UCLA.
	I confirm that I have completed the clinical clerkships as required by the California Medical Board in order to obtain the Post Training Authorization Letter (PTAL). Additional information may be found at: http://www.medbd.ca.gov/applicant/application_international.pdf).
	If accepted to UCLA IMG Program, I will participate fully in the program and abide by all the rules and regulations as stipulated by the program.
	If accepted to the UCLA IMG Program and I successfully advance to and complete Program C, I agree to volunteer a minimum of eight (8) hours per week to facilitate communication between Spanish-speaking patients and the health care team.
	I agree to apply to any and all California Family Medicine residency training programs, regardless of location. I understand that this may require *relocation*.
	I fully understand that if I do not "match" in a Family Medicine Residency Program in California immediately after completing the program, then I will be obligated to work with the program to prepare for the next match year.
	I fully acknowledge that upon completion of a three-year Family Medicine Residency Program in California, I will work full-time in an underserved area in California approved by the program directors.
(*Optional)*	My contact information may be provided to Kaplan Test Prep Center in Pasadena, CA or other educational institutions.

I understand the commitment to serve in a California medically underserved community immediately following completion of a California Family Medicine Residency Training Program as applicable to this application (please initial as applicable below.)

If, for any reason, I breach this contract, at any time once accepted to the program, I will be compelled to compensate the program up to triple the average cost per IMG graduate up to $120,000.

_____for a 3-year period if accepted into Program A or Program B

_____for a 2-year period if accepted into Program C

Signature: _____ Date: _____