Dear Residency Applicant:

Thank you for your interest in the University of California, Davis Network of Affiliated Family Medicine Residency Programs. The primary objective of the Family Medicine Residency Network is to provide a rich graduate experience in family medicine, which implements the principles of the American Academy of Family Physicians, the Accreditation Council on Graduate Medical Education and the American Board of Family Practice. It is our goal to train high-quality family physicians to meet the health care needs of California, to practice with medically under-served populations and to be leaders in their medical communities. The UCD Family Medicine Residency Network includes seven individual programs. Each program is listed below. *Our affiliated program at Travis Air Force Base administers its own resident recruitment program. You may contact them directly for application information.

<table>
<thead>
<tr>
<th>FACILITY &amp; LOCATION</th>
<th>DIRECTOR</th>
<th>PHONE</th>
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<tbody>
<tr>
<td>Contra Costa Regional Medical Center, Martinez</td>
<td>Jeremy Fish, MD</td>
<td>925-370-5117</td>
</tr>
<tr>
<td>Mercy Medical Center, Merced</td>
<td>John Paik-Tesch, MD</td>
<td>209-564-3513</td>
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<tr>
<td>Doctors Medical Center, Modesto</td>
<td>Peter Broderick, MD</td>
<td>209-576-3528</td>
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<tr>
<td>Mercy Medical Center, Redding</td>
<td>Duane Bland, MD</td>
<td>530-225-6090</td>
</tr>
<tr>
<td>UC Davis Health System, Sacramento</td>
<td>Thomas Balsbaugh, MD</td>
<td>916-734-2833</td>
</tr>
<tr>
<td>San Joaquin General Hospital, Stockton</td>
<td>Ramiro Zuniga, MD</td>
<td>209-468-6768</td>
</tr>
<tr>
<td>*David Grant Medical Center, Travis AFB</td>
<td>Pamela Williams, MD</td>
<td>707-423-5349</td>
</tr>
</tbody>
</table>

Your application will be forwarded to the Network Residency Directors at the above programs as openings become available. Your application will be filed for three years. Please refer to the enclosed instructions when completing your application.

Should you have any questions, please feel free to call the Residency Network Recruitment Coordinator between 8:30 a.m. – 4:30 p.m. at 1-800-792-9064. If you leave a message, please speak slowly and clearly and include as much information as possible including where you can be reached, your email address and the best time to call. The Network Recruitment Coordinator will return your call as soon as possible.

Sincerely,

Ronald Fong, MD, MPH
Ronald Fong, MD, MPH
Network Director
UC Davis Network of Affiliated
Family Medicine Residency Programs
Instructions for application:

1. Complete the attached application form and mail or fax it in as soon as possible. CVs are not accepted in lieu of an application.

2. The application process for our Network is centralized at the University of California, Davis, Sacramento office. Please send your application, personal statement, dean’s letter, USMLE transcripts and three letters of recommendation to:

   Recruitment Coordinator
   Dept. of Family & Community Medicine
   4860 Y Street, Suite 2300
   Sacramento, CA  95817
   Fax:  916-734-5641

   Your application package will be forwarded to the affiliate program(s) which you have selected. For information regarding Network programs, you may log on to our website at: http://fpnetwork.ucdavis.edu.

3. Please advise our office of all changes of address and phone number. Without current information, critical correspondence could be missed and the processing of your application jeopardized.

4. INTERNATIONAL MEDICAL SCHOOL GRADUATES: Graduates of foreign medical schools are required to have current ECFMG certification with no deficiencies (depending on the examination taken to obtain ECFMG certification, passing scores on the FLEX or USMLE Transcript may also be required) and a valid Evaluation Status Letter from the Medical Board of California before beginning postgraduate training in any of the Family Medicine Residency programs. J1 visas only.

   Your application cannot be processed until verification of the above has been received by the Network Office.

   For information regarding license requirements in California, please contact the Medical Board of California. They can be reached at 916-263-2499.

   PLEASE NOTE: If you have completed 24 months (36 months for IMGs) of post graduate training, you must have a California Medical License to start a residency program in California.

   QUICK CHECKLIST:
   - Application
   - Personal Statement
   - 3 Letters of Recommendation
   - Dean’s Letter
   - Official USMLE Transcripts
   - Valid ECFMG Certificate (if an IMG)
   - Current California Status Letter (if an IMG)
   - Letter from your Program Director indicating satisfactory completion of internship with a list of completed rotations.
   - Copies of all intern evaluations
Please check the program(s) you are applying to:
- Martinez/Contra Costa Regional Med. Ctr.
- Merced/Mercy Medical Center
- Modesto/Doctors Medical Center
- Redding/Mercy Medical Center
- Stockton/San Joaquin General Hospital
- Sacramento/UC Davis Medical Center

NAME

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Mailing Address

________________________________________________________________________

________________________________________________________________________

School or Hospital Address

________________________________________________________________________

Telephone Number

________________________________________________________________________

Email Address

________________________________________________________________________

Social Security Number: -- --
U.S. Citizen: □ Yes □ No
Other: _______________________________________________________________

The Residency Network only accepts J1 visas.

Do you have a J1 visa? □ Yes □ No

Are you licensed to practice in California?
□ Yes □ No

Do you have military, National Health Service Corps or other public health service obligations?
□ Yes □ No

/Test Scores - Circle test taken

USMLE - COMPLEX - NBOME - FLEX - OTHER

Part I __________ # of times taken: __________
Part II __________ # of times taken: __________
Part III __________ # of times taken: __________

Professional Memberships & Awards
________________________________________________________________________

Are you licensed to practice in California?
□ Yes □ No

List all states you have a medical license in:
________________________________________________________________________

Have you ever been voluntarily or involuntarily suspended from a Residency Program or Medical Staff?
□ Yes □ No

(Please explain)

Please describe your plans for future practice:
________________________________________________________________________

Foreign Languages: (Other than English, list fluencies)
________________________________________________________________________

Emergency Contact Information

Name: ____________________________
Relationship: ______________________
Phone #: __________________________

INTERNATIONAL MEDICAL GRADUATES ONLY:

Do you have a valid ECFMG certificate?
□ Yes □ No

Do you have a valid California Evaluation Status Letter issued by the California Medical Board?
□ Yes □ No

If no, have you applied for it?
□ Yes □ No

(Date submitted to CA Board)
**EDUCATION**

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<tr>
<th>HIGH SCHOOL</th>
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<td>City/State</td>
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<th>COLLEGE</th>
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<tr>
<td>City/State</td>
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<td>Graduation Date</td>
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<td>Degree Earned</td>
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<td>Honors</td>
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<th>MEDICAL SCHOOL</th>
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**ELECTIVES** in Family Medicine, Primary Care, Rural

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<tr>
<td>Degree Earned/Satisfactorily Completed</td>
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**PUBLICATIONS & PRESENTATIONS**

*You may submit a CV for this section.*

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**RESEARCH OR EXPERIMENTAL WORK**

*You may submit a CV for this section.*

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**OTHER TRAINING/GRAD/POSTGRADUATE**

*Please list residencies, sub-specialty training, teaching appointments or experience in general practice.*

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**Reason For Leaving Your Current Residency Program:**

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</table>
PERSONAL STATEMENT

You may either use this form or submit your own. Please do not use a font smaller than 12 pt.
RESUME & ADDITIONAL INFORMATION

* Beginning with the most recent dates, please account for your time from the present to high school graduation. Please include all time periods you were not in school or employed, any part-time appointments, observerships and/or account for time gaps greater than three months.

______________________________________
From:                     To:
______________________________________
Education/Work Experience
Location
Position/Degree/Certificate

*******************************************************************************

______________________________________
From:                     To:
______________________________________
Education/Work Experience
Location
Position/Degree/Certificate

*******************************************************************************

______________________________________
From:                     To:
______________________________________
Education/Work Experience
Location
Position/Degree/Certificate

*******************************************************************************

*You may attach a resume for additional information, but please do not submit a resume in place of the above.

PLEASE NOTE:
If you have completed 24 months (36 months for International Medical Graduates) of post graduate training, you must have a California Medical License to start a residency program in California. For further information on this requirement, please contact the California Medical Board directly by calling (916) 263-2499.

INTERNAL USE ONLY:

Date Received: ____________________________
Received By: ________________________

Verification of Supplemental Material:

☐ Application
☐ Personal Statement
☐ Three Letters of Recommendation
☐ Dean’s Letter
☐ Official USMLE Transcripts
☐ Valid ECFMG Certificate
☐ Current California Status Letter
☐ Program Director Letter
☐ Evaluations

Interview Date: _______________________  Confirmed By: ______________________

YOU MUST SIGN & DATE YOUR APPLICATION
Please make sure your application is complete and that all supplemental material is present. Submitting an incomplete package will delay processing and review of your application.

APPLICANT SIGNATURE
I certify that the information submitted on this application is complete and correct to the best of my knowledge. I understand that any false or missing information may disqualify me for this position.

Print Name: ________________________________  Signature: __________________________