

UNIVERSITY OF IOWA

Clinical Medical Physics Residency Program in Radiation Oncology
(319) 384-6135 (Office)
(319) 356-1530 (Fax)

APPLICATION FOR ADMISSION

Type or print responses to the following information:

Personal Information

Name _____
Last First Middle Maiden

Social Security Number (optional) _____

Present Mailing Address _____
Street City/State/Zip Until What Date?

Permanent Address (if different) _____
Street City/State/Zip

Present Telephone Number: (_____) _____

Permanent Telephone Number: (_____) _____

E-mail Address: _____

Date of Birth _____

Place of Birth _____

Citizenship _____

Visa type _____

Expected Visa Type(s) _____

Criminal History

Have you ever been convicted of a crime? _____ Yes _____ No

If yes, please explain on a separate sheet of paper.

Education

College, university or other post-graduate schools attended:

Name of School	City and State	Degree	Year Awarded	Major Field of Study

Employment History

List all employment (begin with most recent employer). Use additional pages if necessary.

<u>Employer/Address</u>	<u>Type of Work</u>	<u>Dates</u>
1. _____		
2. _____		
3. _____		

References

List three professional references. (Please have the letters sent to the Medical Physics Residency Program by deadline on Program Description page).

<u>Name</u>	<u>Department/Position</u>	<u>Institution</u>
1. _____		
2. _____		
3. _____		

Waiver of Access to Reference Statements

Under the Family Educational and Privacy Rights Act, 20 U.S. c. 1232(g), you may, but are not required to waive your right of access to confidential references given in connection with this application. If you waive your right of access, the waiver remains valid indefinitely. Check the appropriate space below:

- _____ I do waive my right of access
- _____ I do not waive my right of access

Signature _____ Date _____

Please provide a letter of intent detailing your interests and goals for this medical physics training program.

Please Read Carefully Before Signing:

The responses given above are true and correct. I understand that any omissions of fact or any false or misleading statements will be considered just cause for dismissal from the program. I agree that all former employers or former faculty with whom I have been associated may furnish the University of Iowa, Department of Radiation Oncology with all information regarding my character and qualifications, and I release all such employers and faculty from any liability for providing such information in good faith.

I understand that this application will become inactive after one year.

I understand that I am responsible to have my official transcript(s) of grades from prior undergraduate and graduate academic institutions and letters of reference forwarded (by each school and person giving reference) directly to:

Diane Crossett
 Medical Physics Residency Coordinator
 Department of Radiation Oncology
 200 Hawkins Drive LL West Addition
 Iowa City, IA 52242

Signature of Applicant _____ Date _____

Privacy Statement

All information on this form is private. It will be used to identify and communicate with you, and to determine your qualifications for admission to this program. All items requested on the form are required to process your application, except for those identified as optional (social security number and date of birth). Failure to provide the optional items will have no effect on your application, however, if you are accepted into the program, you must provide a social security number in order to receive a paycheck. Those who may gain access to the information in your file are staff and faculty at the University who have a need to know the information to perform their job responsibilities, and outside organization and government bodies in limited circumstances as authorized by state or federal law. In addition, you may review your own file. No one else may review your file without your written consent or a subpoena or court order.