Print Form

ERAS 2014 - MyERAS Application Worksheet

This worksheet may be printed and used to begin completing your MyERAS Application off-line.

Questions represent both the Profile portion of MyERAS as well as your online application. **All required fields are highlighted in red.** Please note, however, that some of these fields are required only in certain circumstances.

Profile

First Name | Middle Name | Last Name

Suffix | Previous Last Name | Preferred Name

Contact E-mail

Last 4 Digits of SSN

Present Mailing Address

Country

Street Address

City | State/Province | Zip/Postal Code

Preferred Phone | Alternate Phone | Pager

Mobile | Fax

Citizenship

- ◯ US Citizen
- ◯ Non- US Citizen - Please indicate one of the following:

Current Visa/Employment Authorization *(Select all that may apply):*

- B-1 – Temporary Visitor for Business
- B-2 – Temporary Visitor for Pleasure
- F-1 – Academic Student (Employment Authorization Document - Optional Practical Training)
- F-2 – Spouse or Child of F-1
- H-1 – Temporary Worker
- H-1B – Special occupation, DoD worker, etcetera
- H-2B – Temporary worker - skilled and unskilled
- H-4 – Spouse or Child of H-1, H-2, H-3
- J-1 – Visa for exchange visitor
- J-2 – Spouse or Child of J-1 Employment Authorization Document (EAD)
- O-1 – Person of Extraordinary Ability in science, arts, education, business or athletics
- TN – NAFTA Trade for Canadians and Mexicans
- E-2 – Treaty Investor, Spouse and Child (EAD)
- Diplomatic Service
- Employment Authorization Document (EAD)
- Other

Use *Ctrl* to select multiple values.

If you are a foreign national, outside the US, or currently in the US in valid visa status, please respond:
Will you need "visa sponsorship" through ECFMG (J-1) or the teaching hospital (H1B) in order to participate in US residency training?

◯ Yes ◯ No*

*If no, Expected Visa/Employment Authorization *(Select all that may apply):*

B-1 – Temporary Visitor for Business
B-2 – Temporary Visitor for Pleasure
F-1 – Academic Student (Employment Authorization Document - Optional Practical Training)
F-2 – Spouse or Child of F-1
H-1 – Temporary Worker
H-1B – Special occupation, DoD worker, etcetera
H-2B – Temporary worker - skilled and unskilled
H-4 – Spouse or Child of H-1, H-2, H-3
J-1 – Visa for exchange visitor
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O-1 – Person of Extraordinary Ability in science, arts, education, business or athletics
TN – NAFTA Trade for Canadians and Mexicans
E-2 – Treaty Investor, Spouse and Child (EAD)
Diplomatic Service
Employment Authorization Document (EAD)
L2 - Dependent of Intra-Company Transferee (EAD)

Use *Ctrl* to select multiple values.

USMLE ID [ ] (Required for USMLE transcript transmission)

NBOME ID [ ] (Required for COMLEX transcript transmission)

AOA Member Number [ ]

NMS Match Information (D.O. Residency Applicants Only)

I plan to participate in the NMS Match ◯ Yes ◯ No

AOA Match Number (NMS number) [ ]

Participating as Couple in NMS ☐

Partner's Name [ ]

Specialties Partner is applying to [ ]

NRMP Match Information

I plan to participate in the NRMP Match ◯ Yes ◯ No

NRMP ID [ ]

Participating as Couple in NRMP ☐

Partner's Name [ ]

Specialties Partner is applying to [ ]

Urology Match Information

AUA Member Number [ ] (Required for Urology Match Participants Only)

☐ I am ACLS (Advanced Cardiac Life Support) certified in the US. Expiration Date [ ] MM / DD / YYYY

☐ I am PALS (Pediatric Advanced Life Support) certified in the US. Expiration Date [ ] MM / DD / YYYY

Alpha Omega Alpha Status (Leave Blank, if Not Applicable) [ ]

Sigma Sigma Phi Status (Leave Blank, if Not Applicable) [ ]

☐ I understand and agree to the AAMC *Privacy Statement* and the *AAMC Policies Regarding the Collection, Use and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data,* and to the transfer of my personal data to those residency programs in the United States and Canada that I select through my application, and to other third parties as stated in the Privacy Policies.

Application

General Tab

Birth Place [ ] Birth Date (MM/DD/YYYY) [ ] Gender [ ]

Permanent Mailing Address ☐ Copy from Profile

Country [ ]

Street Address [ ]

[ ]

City [ ]

State/Province [ ] Zip/Postal Code [ ]

Phone # [ ]

Are you committed to fulfill a US military active duty service obligation/deferment?

◯ Yes ◯ No Years [ ] Branch [ ]

Do you have any other service obligations? (i.e. Military Reserves or Public Health/State programs)

◯ Yes ◯ No Description (255 Char Limit) [ ]

Education Tab

(Include only Higher Education)

This section allows entries for each Undergraduate and Graduate School you have attended.

Entry 1

☐ None

Institution

Location

Education Type

Field of Study

Degree expected or earned

Degree

Degree Month Degree Year

Dates of Attendance

From Month Year

To Month Year *Leave month/year blank if experience is ongoing*

Entry 2

☐ None

Institution

Location

Education Type

Field of Study

Degree expected or earned

Degree

Degree Month Degree Year

Dates of Attendance

From Month Year

To Month Year *Leave month/year blank if experience is ongoing*

Medical Education Tab

This section allows entries for each Medical School you have attended.

Entry 1

Country | Institution

Degree expected or earned

Degree

Degree Month | Degree Year

Dates of Attendance

From Month | Year

To Month | Year *Leave month/year blank if experience is ongoing*

Entry 2

Country | Institution

Degree expected or earned

Degree

Degree Month | Degree Year

Dates of Attendance

From Month | Year

To Month | Year *Leave month/year blank if experience is ongoing*

Training Tab

Current/Prior Training

Please include each **D.O. Internship, D.O. Residency, D.O. Fellowship, M.D. Residency, and/or M.D. Fellowship** in which you have trained, regardless of the length of time spent in training.

Entry 1

☐ None

Type of Training

Specialty

Institution/Program

Country

State/Province

City

Program Director

Supervisor

☐ Chief Resident

Dates of Residency/Osteopathic Internship/Fellowship

From Month Year

To Month Year

Reason for Leaving
(510 Characters)

Entry 2

☐ None

Type of Training

Specialty

Institution/Program

Country

State/Province

City

Program Director

Supervisor

☐ Chief Resident

Dates of Residency/Osteopathic Internship/Fellowship

From Month Year

To Month Year

Reason for Leaving
(510 Characters)

Experience Tab

(Include clinical and teaching experience as work experiences; include all unpaid extra-curricular activities and committees you have served on as volunteer experiences).This section allows entries for each **work, volunteer, or research** experience.

Entry 1

☐ None

Experience Type

Organization

Position

Supervisor

Country

State/Province

City

Average Hours/Week

Description
(1020 Char)

Reason for Leaving
(510 Char)

Dates of Experience

From Month Year

To Month Year *Leave month/year blank if experience is ongoing*

Entry 2

☐ None

Experience Type

Organization

Position

Supervisor

Country

State/Province

City

Average Hours/Week

Description
(1020 Char)

Reason for Leaving
(510 Char)

Dates of Experience

From Month Year

To Month Year *Leave month/year blank if experience is ongoing*

Publications Tab

This section allows entries for each of your publications.

Select from:
Peer Reviewed Journal Articles/Abstracts
Peer Reviewed Journal Articles/Abstracts (Other than Published)
- Statuses: Submitted, Provisional Accepted, Accepted or In-Press

Peer Reviewed Book Chapter
Scientific Monograph
Other Articles
Poster Presentation
Oral Presentation
Peer Reviewed Online Publication
Non Peer Reviewed Online Publication

Peer Reviewed Journal Articles/Abstracts

Title

Author(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

Publication Name

PMID *(Publication Med-Line Unique Identifier)*

Volume

Issue No.

Pages *(eg. 200-212)*

Month Year

Peer Reviewed Journal Articles/Abstracts (Other than Published)

Title

Author(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

Publication Name

Publication Status Month Year

Peer Reviewed Book Chapter

Chapter Title

Name of Book

Author(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

Editor(s)

Publisher

City

Year

Scientific Monograph

Title

Publication Name

Volume

Issue No.

(eg. 200-212)

Author(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

Year

Other Articles

Title

Author(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

Publication Name

Month Day Year

Poster Presentation

Title

Author(s)/Presenter(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

Event/Meeting

Country

State/Province

City

Year

Oral Presentation

Title

Author(s)/Presenter(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

Event/Meeting

Country

State/Province

City

Month Year

Peer Reviewed Online Publication

Title

Author(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

URL

Month Day Year

Non Peer Reviewed Online Publication

Title

Author(s)

***Format**:*
For one author: LastName FirstInitialMiddleInitial
For multiple authors: LastName FirstInitialMiddleInitial, LastName FirstInitialMiddleInitial

URL

Month Day Year

Licensure Information Tab

Has your medical license ever been suspended/revoked/voluntarily terminated?

◯ Yes ◯ No Month Day Year

Reason
(510 Char)

Have you ever been named in a malpractice case?

◯ Yes ◯ No

Reason
(510 Char)

Is there anything in your past history that would limit your ability to be licensed or would limit you ability to receive hospital privileges?

◯ Yes ◯ No

Reason
(510 Char)

Have you ever been convicted of a misdemeanor in the United States?

◯ Yes ◯ No

If yes, explain
(510 Char)

Have you ever been convicted of a felony in the United States?

◯ Yes ◯ No

If yes, explain
(510 Char)

Are you Board Certified?

◯ Yes ◯ No

Board Name

DEA Registration Number

Expiration Month Expiration Year

Note: DEA is for US Medical License holders only

Medical Licenses Tab

State Medical Licenses

This section allows entries for each of your state medical licenses.

☐ None

Entry 1

State

License Type:

License Number

Expiration Month Expiration Year

Entry 2

State

License Type:

License Number

Expiration Month Expiration Year

Self Identify

If you are a citizen of a European Country, you should not answer this question. Please select "Prefer not to say."

If you prefer not to self-identify, please select "Prefer not to say" and save. If you select a major category, a subcategory or "Other" must be selected. You are required to enter text in the field next to "Other." The "Other" text field is limited to 120 characters.

How do you self-identify? Please select all that apply.

- [ ] Prefer not to say
- [ ] Hispanic, Latino, or of Spanish origin
  - [ ] Argentinean
  - [ ] Colombian
  - [ ] Cuban
  - [ ] Dominican
  - [ ] Mexico/Chicano
  - [ ] Peruvian
  - [ ] Puerto Rican
  - Other
- [ ] American Indian or Alaskan Native
  - Tribal affiliation
- [ ] Asian
  - [ ] Bangladeshi
  - [ ] Cambodian
  - [ ] Chinese
  - [ ] Filipino

- [ ] Japanese
- [ ] Korean
- [ ] Indian
- [ ] Indonesian
- [ ] Laotian
- [ ] Pakistani
- [ ] Taiwanese
- [ ] Vietnamese
- [ ] Other

- [ ] Black or African American
  - [ ] African American
  - [ ] Afro-Caribbean
  - [ ] African
  - [ ] Other
- [ ] Native Hawaiian
  - [ ] Native Hawaiian
  - [ ] Guamanian
  - [ ] Samoan
  - [ ] Other
- [ ] White

Other

Language Fluency

What languages do you speak? Select all that apply. For each language that you select, including English, you will be asked to rate your proficiency in that language using the guidelines provided below.

Native/functionally native:
I converse easily and accurately in all types of situations. Native speakers, including the highly educated, may think that I am a native speaker, too.

Advanced:
I speak very accurately, and I understand other speakers very accurately. Native speakers have no problem understanding me, but they probably perceive that I am not a native speaker.

Good:
I speak well enough to participate in most conversations. Native speakers notice some errors in my speech or my understanding, but my errors rarely cause misunderstanding. I have some difficulty communicating necessary health concepts.

Fair:
I speak and understand well enough to have extended conversations about current events, work, family, or personal life. Native speakers notice many errors in my speech or my understanding. I have difficulty communicating about healthcare concepts.

Basic:
I speak the language imperfectly and only to a limited degree and in limited situations. I have difficulty in or understanding extended conversations. I am unable to understand or communicate most healthcare concepts.

- ☐ Albanian
- ☐ American Sign Language
- ☐ Amharic
- ☐ Arabic
- ☐ Armenian
- ☐ Bantu
- ☐ Bengali
- ☐ Bulgarian
- ☐ Burmese
- ☐ Cajun
- ☐ Chinese
- ☐ Croatian
- ☐ Cushite
- ☐ Czech
- ☐ Danish
- ☐ Dutch
- ☐ English
- ☐ Finnish
- ☐ Formosan
- ☐ French
- ☐ French Creole
- ☐ German
- ☐ Greek
- ☐ Gujarati
- ☐ Hebrew
- ☐ Hindi
- ☐ Hmong
- ☐ Hungarian
- ☐ Ilocano
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Kannada
- ☐ Korean
- ☐ Kru, Ibo, Yoruba
- ☐ Laotian
- ☐ Lithuanian
- ☐ Malayalam
- ☐ Mande
- ☐ Marathi
- ☐ Mon-Khmer, Cambodian
- ☐ Navajo
- ☐ Nepali
- ☐ Norwegian
- ☐ Patois
- ☐ Pennsylvania Dutch
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Romanian
- ☐ Russian
- ☐ Samoan
- ☐ Serbian
- ☐ Serbocroatian
- ☐ Slovak
- ☐ Spanish/Spanish Creole
- ☐ Swahili
- ☐ Syriac
- ☐ Tagalog
- ☐ Tamil
- ☐ Telugu
- ☐ Thai
- ☐ Tongan
- ☐ Turkish
- ☐ Ukrainian
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish

Miscellaneous Tab

The following two questions are to be answered by IMG residency applicants only.

Will you or your medical school provide a MSPE to the ERAS Documents office at ECFMG?

◯ Yes ◯ No

Will you or your medical school provide a transcript to the ERAS Documents office at ECFMG?

◯ Yes ◯ No

Are you able to carry out the responsibilities of a resident, intern, or fellow in the specialties and at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?

◯ Yes ◯ No ◯ No Response

Limiting Aspects
(510 Char)

Was your medical education/training extended or interrupted?

◯ Yes ◯ No

Reason
(510 Char)

Hobbies & Interests
(510 Char)

Medical School Awards
(510 Char)

Other Awards/ Accomplishments (510 Char)	

Membership in Honorary/ Professional Societies (255 Char Limit)	

When you are ready to certify and submit your online MyERAS Application, ERAS will require you to acknowledge the following statement:

I certify that the information contained within the MyERAS application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; may result in an investigation by the AAMC; may also result in expulsion from ERAS; or if employed, may constitute cause for termination from the program. I also understand and agree to the AAMC Web Site Terms and Conditions, AAMC Privacy Statement, and the *AAMC Policies Regarding the Collection, Use and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data* and to the AAMC's collection and other processing of my personal data according to these Privacy Policies. In addition, I consent to the transfer of my personal data to AAMC in the United States, to those residency programs in the United States and Canada that I select through my application, and to other third parties as stated in the Privacy Policies.