

ERAS Applicant Worksheet



This worksheet may be printed and used to begin completing your MyERAS application offline.
All required fields are highlighted in red and marked with an asterisk.
Please note: Some of these fields are required only in certain circumstances.

AAMC Account Information

First Name*

Sex*

Middle Name

Email*

Last Name*

Birth Date*

Suffix

I authorize the release of my birth date to programs

Basic Information

Previous Last Name

Preferred Phone*

Preferred Name

Mobile Phone

Alternate Phone

Fax

Pager

Address

Current Mailing Address

Address 1*

Address 2

Country*

State

(Required for U.S. & Canadian addresses)

City*

Postal Code

Is your permanent address the same as your current mailing address?* Yes No

Permanent Address

Address 1

Address 2

Country

State

City

Postal Code

Phone

Work Authorization

Are you currently authorized to work in the United States?* Yes No

What is your current work authorization?*

Will you need visa sponsorship through ECFMG (J-1) or the teaching hospital (H-1B) to complete the entirety of your GME training?*

Yes No

If yes, please select the visa(s) for which you will seek sponsorship. Select all that apply.*

H-1B J-1

*Eligibility for ECFMG J-1 visa sponsorship is not to be presumed. For details on ECFMG J-1 requirements and restrictions, please visit <http://www.ecfm.org/evsp/requirements.html>.

If no, please identify which of the following will serve as your basis for work authorization for the entirety of your GME training without any need for visa sponsorship. Select all that apply.*

- Legal Permanent Resident, Refugee, Asylee
- Adjustment of Status applicant (Green Card application) (EAD)
- DACA – Deferred Action for Childhood Arrivals
- Diplomatic Service
- E-2 – Treaty investor, spouse, and children (EAD)
- Employment Authorization Document (EAD)
- F-1 – Academic student (EAD, OPT)
- H-1 – Temporary worker
- H-1B – Specialty occupation, DoD worker, etc.
- H-2B – Temporary worker - skilled and unskilled
- H-4 – Spouse or child of H-1, H-2, H2-3 (EAD)
- J-1 – Visa for exchange visitor
- J-2 – Spouse or child of J-1 (EAD)
- L-2 – Dependent of Intra-Company Transferee (EAD)
- O-1 – Extraordinary ability in sciences, arts, education, business, or athletics
- TN – NAFTA trade visa for Canadians and Mexicans
- Other

If you currently reside in the United States or Canada, please identify your current state or province of residency.

Match Information

NRMP Match

I plan to participate in the NRMP match?* Yes No

If yes, NRMP ID:

Participating as a couple in NRMP? Yes No

If yes, partner's name:

Specialties partner is applying to:

Urology Match

AUA Member Number:

Additional Information

USMLE/ECFMG ID:

NBOME ID: *(Required for D.O. applicants)*

AOA Member Number:

I am ACLS (Advanced Cardiovascular Life Support) certified in the U.S.: Yes No

If yes, ACLS expiration date:

I am PALS (Pediatric Advanced Life Support) certified in the U.S.: Yes No

If yes, PALS expiration date:

I am BLS (Basic Life Support) certified in the U.S.: Yes No

If yes, BLS expiration date:

Sigma Sigma Phi Status: *(D.O. applicants only)*

Alpha Omega Alpha Status:

Gold Humanism Honor Society Status:

Biographic Information

Self-Identification

This section allows you to indicate how you self-identify. When selecting "Other" as a subcategory, the text field is limited to 120 characters; however, it is not a required field. If you prefer not to self-identify or if you reside in the European Union, please ignore this section.

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

Hispanic, Latino, or of Spanish origin

Argentinean

Colombian

Cuban

Dominican

Mexican/Chicano

Peruvian

Puerto Rican

Other Hispanic:

American Indian or Alaska Native

Tribal affiliation:

Asian

Bangladeshi

Cambodian

Chinese

Filipino

Indian

Indonesian

Japanese

Korean

Laotian

Pakistani

Taiwanese

Vietnamese

Other Asian:

Black or African American

African American

Afro-Caribbean

African

Other Black:

Native Hawaiian or Pacific Islander

Guamanian

Native Hawaiian

Samoan

Other Pacific Islander:

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 care 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 health care 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 health care concepts.

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

Military Information

Are you committed to fulfill a U.S. military active duty service obligation/deferment?*

Yes

No

If yes, number of years remaining:

Branch:

Do you have any other service obligations (e.g., military reserves, public health/state programs, etc.)?*

Yes

No

If yes, describe:

255 Characters Max

Additional Information

Hobbies and Interests:

510 Characters Max

Hometown(s):

50 Characters Max

Education

Higher Education

This section allows multiple entries for each undergraduate and graduate school you have attached.

Since most non-U.S. educational systems do not follow the U.S. model, almost all students and graduates of international medical schools will indicate "None."

None

Entry 1

Institution*

Location*

Education Type*

Field of Study*

Degree Expected or Earned*

If Yes: Degree

Month

Year

Dates of Attendance: From Month*

From Year*

To Month*

To Year*

Entry 2

Institution*

Location*

Education Type*

Field of Study*

Degree Expected or Earned*

If Yes: Degree

Month

Year

Dates of Attendance: From Month*

From Year*

To Month*

To Year*

Medical Education

This section allows entries for each medical school you have attended.

Entry 1

Country*

Institution*

Degree*

Degree Month*

Degree Year*

Dates of Education

From Month*

From Year*

To Month*

To Year*

Entry 2

Country*

Institution*

Degree*

Degree Month*

Degree Year*

Dates of Education

From Month*

From Year*

To Month*

To Year*

Additional Information

Membership in
Honorary/Professional
Societies:

255 Characters Max

Medical School
Awards:

510 Characters Max

Other Awards/
Accomplishments:

510 Characters Max

Experience

Training

Please add an entry for any current or prior AOA Internship, AOA Residency, AOA Fellowship, ACGME Residency, or ACGME/RCPSC/UCNS Fellowship in which you have trained, regardless of the length of time spent in the training. Save the file after completing the required fields. Additional entries may be added as needed.

None

Entry 1

Type of Training*

Specialty*

Institution/Program*

Country*

State/Province

City*

Program Director*

Supervisor*

Dates of Residency/Fellowship:

From Month*

From Year*

To Month*

To Year*

Reason for Leaving:

510 Characters Max

Entry 2

Type of Training*

Specialty*

Institution/Program*

Country*

State/Province

City*

Program Director*

Supervisor*

Dates of Residency/Fellowship:

From Month*

From Year*

To Month*

To Year*

Reason for Leaving:

510 Characters Max

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Experience

Please add any additional experience. Clinical and teaching experience should be treated as work experience. Include all unpaid extracurricular activities and committees on which you have served as Volunteer Experience.

None

Entry 1

Experience Type*

Organization*

Position*

Supervisor

Country*

State/Province

City*

Average Hours/Week

Description:

1020 Characters Max

Reason for Leaving:

510 Characters Max

Dates of Experience:

From Month*

From Year*

To Month*

To Year*

Entry 2

Experience Type*

Organization*

Position*

Supervisor

Country*

State/Province

City*

Average Hours/Week

Description:

1020 Characters Max

Reason for Leaving:

510 Characters Max

Dates of Experience:

From Month*

From Year*

To Month*

To Year*

Additional Information

Was your medical education/training extended or interrupted?*

Yes

No

If yes, please
provide details.
510 Characters Max

Licensure

Please add an entry for any 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*

Additional Information

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

Yes

No

If yes,
please explain:

Have you been named in a malpractice case?*

Yes

No

If yes,
please explain:

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

(Note: This section is not intended to solicit information about your health, disability, or family status.)

Yes

No

If yes,
please explain:

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

Yes

No

If yes,
please explain:

ERAS Applicant Worksheet (continued)

Have you ever been convicted of a felony in the United States?* Yes No

If yes,
please explain:

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

Yes No No Response

Are you Board Certified?* Yes No

If yes, Board Name:

DEA Registration Number:

Expiration Month

Expiration Year

Publications

Add an entry for each of your publications.

Peer-Reviewed Journal Articles/Abstracts

Journal Article(s)/
Abstract(s) Title*
255 Characters Max

Author(s)*

(Last Name, First Initial, Middle Initial)

Publication Name*

Publication Med-Line Unique Identifier (PMID)

Publication Volume*

Issue Number*

Pages* *(e.g., 200-212)*

Month* Year*

Peer-Reviewed Journal Articles/Abstracts (Other than Published)

Journal Article(s)/
Abstract(s) Title*
255 Characters Max

Author(s)*

(Last Name, First Initial, Middle Initial)

Publication Name*

Publication Status*

Month* Year*

Peer-Reviewed Book Chapter

Chapter Title*
255 Characters Max

Name of Book*

Author(s)* *(Last Name, First Initial, Middle Initial)*

Editor(s)* *(First Initial, Middle Initial, Last Name)*

Publisher*

Pages* *(e.g., 200-212)*

Country*

State/Province

City*

Year*

Scientific Monograph

Monograph Title*
255 Characters Max

Publication Name*

Volume*

Issue Number*
(e.g., 200-212)

Author(s)* *(Last Name, First Initial, Middle Initial)*

Editor(s)* *(First Initial, Middle Initial, Last Name)*

Publisher*

Year*

Other Articles

Title of Other Article*
255 Characters Max

Author(s)* *(Last Name, First Initial, Middle Initial)*

Publication Name*

Publication Date* *(MM/DD/YYYY)*

Poster Presentation

Poster Presentation Title*
255 Characters Max

Author(s)/Presenter(s)*

(Last Name, First Initial, Middle Initial)

Event/Meeting*

Country*

State/Province

City*

Month*

Year*

Oral Presentation

Oral Presentation Title*
255 Characters Max

Author(s)/Presenter(s)*

(Last Name, First Initial, Middle Initial)

Event/Meeting*

Country*

State/Province

City*

Month*

Year*

Peer-Reviewed Online Publication

Online Publication Title*
255 Characters Max

Author(s)*

(Last Name, First Initial, Middle Initial)

URL*

Publication Date*

(MM/DD/YYYY)

Non-Peer-Reviewed Online Publication

Online Publication Title*
255 Characters Max

Author(s)*

(Last Name, First Initial, Middle Initial)

URL*

Publication Date*

(MM/DD/YYYY)

Certification

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 per the [attached policy](#) (PDF); 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](#) and 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 these 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 these Privacy Policies.*