

ERAS 2018 MyERAS Application Worksheet

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

All required fields are highlighted in red and marked with an asterisks. Please note, that some of these fields are required only in certain circumstances.

Personal Information

Contact Information

First Name*

Preferred Phone*

Middle Name

Mobile Phone

Last Name*

Alternate Phone

Previous Last Name

Fax

Suffix

Pager

Preferred Name

Email*

Last 4 digits of SSN

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

Citizenship Information

Are you a U.S. citizen?* Yes No

If yes, are you a citizen of a country in addition to the United States? Yes No

If yes, select your country of dual citizenship (other than the United States):

If you are not a U.S. citizen, select citizenship status:

If you are a Foreign National currently in in the U.S. with Valid Visa Status, select your current Visa/Employment Authorization Status:

If you are a Foreign national, outside the U.S. or currently in the U.S. , with a valid visa status, please respond: Will you need visa sponsorship through the ECFMG (J-1) or the teaching hospital (H-1B) in order to participate in U.S. residency and/or fellowship training? Yes No

If yes, please select the visa(s) you would like to apply for. Select all that apply. The system will list your Expected Visa/Employment Authorization based on your selections. 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 see refer to ECFMG/EVSP website at <http://www.ecfm.org/evsp/requirements.html>

If no, Expected Visa/Employment Authorization Status (the visa status you expect to secure with Employment Authorization to participate in a program):

If applicable, please indicate your state or province of residence in the United States or Canada:

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:

NMS Match

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

If yes, AOA Match Number (NMS Number):

Participating as a couple in the NMS: 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.A.: Yes No

If yes, ACLS Expiration Date:

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

If yes, PALS Expiration Date:

I am BLS (Basic Life Support) certified in the U.S.A.: 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

General

Gender*

Birth Place

Birth Date

Self Identification

If you reside in the European Union, do not answer this question. Please ignore this section.

This section allows you to indicate how you self-identify. When selecting "Other" as a sub-category, the text field is limited to 120 characters but is not required field. If you prefer not to self-identify, please ignore this section.

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

Hispanic, Latino or of Spanish origin

Colombian

Argentinean

Cuban

Dominican

Mexican/Chicano

Peruvian

Puerto Rican

Other Hispanic:

American Indian or Alaskan 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 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.

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

Military Information

Are you committed to fulfill a U.S. military active duty service obligations/deferments?* 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 Character Max

Additional Information

Hobbies &
Interests
510 Character 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*

Dates of Attendance: From Month*

From Year*

To Month*

To Year*

Entry 2

Institution*

Location*

Education Type*

Field of Study*

Degree expected or earned*

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*	<input type="text"/>		
Institution*	<input type="text"/>		
Degree*	<input type="text"/>		
Degree Month*	<input type="text"/>	Degree Year*	<input type="text"/>
Dates of Education*			
From Month*	<input type="text"/>	From Year*	<input type="text"/>
To Month*	<input type="text"/>	To Year*	<input type="text"/>

Entry 2

Country*	<input type="text"/>		
Institution*	<input type="text"/>		
Degree*	<input type="text"/>		
Degree Month*	<input type="text"/>	Degree Year*	<input type="text"/>
Dates of Education			
From Month*	<input type="text"/>	From Year*	<input type="text"/>
To Month*	<input type="text"/>	To Year*	<input type="text"/>

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 any current or prior D.O. Internship, D.O. Residency, M.D. Residency or M.D. Fellowship in which you have trained, regardless of length of time spent in the training.

None

Entry 1

Type of Training*

Specialty*

Institution/Program*

Country*

State/Province

City*

Program Director*

Supervisor*

Chief Resident

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*

Chief Resident

Dates of Residency/Fellowship

From Month* From Year* To Month* To Year*

Reason for Leaving
510 Characters Max

Experience

Please add your additional experience. Clinical and Teaching experience should be treated as Work experiences. Include all unpaid extra-curricular activities and committees you have served on as a Volunteer experiences.

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 Questions

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?* Yes No

If yes, please
explain:

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

If yes, please
explain:

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 or a 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 with or without reasonable accommodations?* Yes No No Response

If no, please list your limiting aspect(s):

Are you Board Certified?* Yes No

If yes, Board Name

DEA Registration Number

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*

(eg. 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*
225 Characters Max

Name of Book*

Author(s)*

(Last Name, First Initial, Middle Initial)

Editor(s)*

(First Initial, Middle Initial, Last Name)

Publisher*

Pages*

(eg. 200-212)

Country*

State/Province

City*

Year*

Scientific Monograph

Monograph Title*
255 Characters Max

Publication Name*

Volume*

Issue Number*

(eg. 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)*

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 Type*

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)

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.