

# Texas Tech University Health Sciences Center School of Medicine

## Residency Program Graduate Information

Last Name		First Name		Middle Name
Social Security Number		Date of Birth	Sex Male ____ Female ____	Citizenship *
Ethnicity * White ____ Black ____ Hispanic ____ American Indian ____ Asian Pacific/Islander ____ Other (specify) _____				
Permanent Address (Street and Number, City, State, Zip Code):				Home Phone Area Code: (        ) _____ - _____
TTUHSC Campus	Specialty	Beginning Date	Ending Date	
Completed Residency Training? Yes ____ No ____	If No, please state reason:			
Further Post Graduate Training (if any) Residency _____ Fellowship _____			Specialty	
Name and Location of Institution(Street and Number, City, State, Zip code)				

### POST PRACTICE INFORMATION

Post Residency Practice Type (if applicable) Solo ____ Group ____ Academic ____ Institution ____ Other(please specify) _____	
Post Residency Practice Address (clinic, hospital/institution name, street, city, state, zip)	Business Phone Area Code: (        ) _____ - _____
Is the practice site a Medically Underserved Facility, or located in a Medically Underserved Community such as Health Area (HPSA), Medically Underserved Area (MUA), etc? Yes ____ No ____ Don't Know _____	
<p><b><i>If not available now, please forward your practice address to us at the following address when available. Thank You.</i></b></p> <p><b><i>Kathy Kitten, Assistant Director of Graduate Medical Education Graduate Medical Education</i></b></p> <p><b><i>Texas Tech University Health Sciences Center, 3601 4th Street, Lubbock, Texas 79430</i></b></p>	

### Board Certification

Specialty Examination Plan to take exam _____ Passed exam _____	Specialty	Date
Sub-Specialty Examination Plan to take exam _____ Passed exam _____	Sub-Specialty	Date

\* This information is needed for group data reporting to state and federal agencies involved in residency program issues and would not be reported on an individual basis.