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): **E-mail address:**	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 _____

If not available now, please forward your practice address to us at the following address when available. Thank You.
Graduate Medical Education
Texas Tech University Health Sciences Center, 3601 4th Street, STOP 6211, Lubbock, Texas 79430

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.*