

**MEDICAL COLLEGE OF GEORGIA
GRADUATE MEDICAL EDUCATION DATA SHEET**

**The hospital is required to submit the following information to the Centers for Medicare & Medicaid Services.
Please print clearly and return to Graduate Medical Education Office AE 3042**

Medical/Dental School

Name

Name of School

Social Security Number

City and State, or Country if not USA

MCG Residency Program Name

Graduation Date (Month/Day/Year)

Degree

Date entered MCG Residency

ECFMG Certification Date (if Foreign Medical School Graduate)

Please list any previous Internship, Residency, or Fellowship Training in an accredited program within the USA.

From Month/Year	To Month/Year	Program Name	Hospital	City/State
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please identify any time lapse between your graduation from medical school and the date you entered GHSU's residency program, if you have not included it above in a previous residency program.

From Month/Year	To Month/Year	Private practice, foreign residency program, non-medical work experience, etc.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature

Date