UCONN
SCHOOL OF MEDICINE
GRADUATE MEDICAL EDUCATION

MASTER RECORD REPORT

PERSONAL DATA

Last Name: ______________________ First Name: ______________________ Middle Name: ______________________

Social Security Number: __________________________ Citizen of (country): __________________________________

TRAINING PROGRAM YOU ARE ENTERING AT UCONN

Program: __________________________ Level: ___________ Start Date: ______________________
(mm/dd/yy)

EDUCATION

Medical School: ______________________________________ Graduation Date: _______________ Degree: _________
(mm/dd/yy)

ECFMG Number (if applicable): __________________________ ECFMG Certificate Date: _______________________
(mm/dd/yy)

CT STATE MEDICAL LICENSE

☐ Yes ☐ No If yes: Number: ______________________ Expiration Date: ___________________
(mm/dd/yy)

FORMER US RESIDENCY/FELLOWSHIP TRAINING

☐ None

	Program Specialty	Institution	Dates (mm/dd/yy-mm/dd/yy)
1.			
2.			
3.			
4.			