Government of the District of Columbia
Department of Health

HEALTH REGULATION AND LCENSING ADMINISTRATION
BOARD OF MEDICINE

MEDICAL TRAINING REGISTRANT FORM
(FOR RESIDENTS ONLY)

Registrants must complete this form in its entirety. NOTE: If you currently hold a full license to practice medicine in another state you must apply for a Full Medical License or Medical Training License.

SECTION 1. TYPE OF REGISTRATION

☐ **MEDICAL TRAINING REGISTRANT (Rotation 90 days or less) Please note: THIS IS NOT A LICENSE**

☐ **CRIMINAL BACKGROUND CHECK:** For payment and to schedule an appointment Call **1-877-783-4187** or www.L1enrollment.com

***All applicants are required to undergo a Criminal Background Check per DC Official Code Section 3-1205.22**

SECTION 2. MEDICAL TRAINING REGISTRANT INFORMATION

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____
Date of Birth **Social Security Number** **GENDER:** ☐ **MALE** ☐ **FEMALE**

***ATTACH A COPY OF YOUR DRIVER'S LICENSE OR GOVERNMENT ISSUED IDENTIFICATION.**

RACE & ETHNICITY DESIGNATION:

☐ **American Indian/Alaskan Native** ☐ **Asian/South Asian** ☐ **Black or African American** ☐ **Caucasian/White**

☐ **Hispanic or Latino** ☐ **Native Hawaiian or other Pacific Islander** ☐ **Other** _____

Name of Medical School Attended: _____ **Country:**_____ **Graduation Date:** _____

Name of Current Residency Training Program Institution: _____ **State:** _____

Year of Postgraduate Training: ☐ **PGY1** ☐ **PGY2** ☐ **PGY3** ☐ **PGY4** ☐ **Other:** _____

DEGREE(S): ☐ **M.D.,** ☐ **D.O,** ☐**PH.D.,** ☐ **MBBS** ☐ **OTHER DEGREE**_____

Do you currently hold a license to practice medicine in another state or country? ☑ **YES** ☐ **NO**

If yes please list:_____

SECTION 3. ROTATING HOSPITAL

Select the hospital where you will be rotating in the District of Columbia. If rotating through more than one hospital use a separate form for each rotation.

☐ **Children's National Medical Center** ☐ **MedStar Georgetown University Hospital** ☐ **Providence Hospital**

☐ **George Washington University Hospital** ☐ **MedStar National Rehabilitation Hospital** ☐ **Saint Elizabeth's Hospital**

☐ **Howard University Hospital** ☐ **MedStar Washington Hospital Center**

Dates of Rotation: FROM: _____/_____/_____ **TO:** _____/_____/_____

SECTION 4. AFFIDAVIT

I hereby attest that I am in good standing and the information given in this Medical Training Registrant Form is true and complete to the best of my knowledge. I understand that making a false statement on this Form is punishable by criminal penalties.

_____ _____ _____
LICENSEE SIGNATURE ***PRINT NAME*** ***DATE***

***PLEASE NOTE: PRINT AND MAIL ORIGINAL REGISTRANT FORM TO THE ROTATING HOSPITAL PROGRAM FOR THE GME TO REVIEW, VERIFY, AND MAIL THE ORGINIAL EXECUTED REGISTRANT FORM TO THE DC BOARD OF MEDICINE. PLEASE RETAIN A COPY FOR YOUR FILES.**

SECTION 5. GME VERIFICATION (AS PER ROTATING HOSPITAL SELECTED IN SECTION 3)

I have reviewed this Medical Training Registrant Form and I hereby verify that the information provided above is accurate.

_____ _____
(Print Name) **(Signature)**

_____ _____
(Print Title) **(Date)**