



Government of the District of Columbia
Department of Health

HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF MEDICINE



MEDICAL TRAINING REGISTRANT FORM
(Medical Resident Rotations of 120 days or less)

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to **DC Code 22-2405**. If you have any questions, call HRLA Customer Service at (877) 672-2174 Monday through Friday, 8:30AM to 4:00PM EST.

■ **STOP: BEFORE COMPLETING THIS FORM, PLEASE REFER TO APPLICATION INSTRUCTIONS.**

■ **ALL APPLICANTS ARE REQUIRED TO UNDERGO A CRIMINAL BACKGROUND CHECK PER DC OFFICIAL CODE SECTION 3-1205.22.** For payment and to schedule an appointment call 1-877-783-4187 or www.L1enrollment.com

■ **ATTACH A COPY OF A GOVERNMENT ISSUED PHOTO ID.**

■ **THIS FORM MUST BE RECEIVED BY THE DC BOARD OF MEDICINE AT LEAST 30 DAYS PRIOR TO START DATE.**

■ **THERE IS NO FEE ASSOCIATED WITH THIS APPLICATION.**

SECTION 1. MEDICAL TRAINING REGISTRANT INFORMATION

LEGAL NAME: *(Do not use any initials unless they are a part of your name)* GENDER: ☐ MALE ☐ FEMALE

FIRST NAME

MI

LAST NAME

SUFFIX (Jr., Sr. etc.)

DEGREE(S): ☐ MD, ☐ DO, ☐ MBBS, ☐ MBA, ☐ MPH, ☐ PHD., ☐ OTHER DEGREE

/ /
Date of Birth

Place of Birth: State/Province/Territory

Country if not USA

- -
Social Security Number

PHONE: _____

EMAIL ADDRESS: _____

SECTION 2. MEDICAL TRAINING BACKGROUND

NAME OF MEDICAL SCHOOL ATTENDED: _____ COUNTRY: _____ GRADUATION DATE: _____

NAME OF CURRENT RESIDENCY TRAINING PROGRAM INSTITUTION: _____ STATE: _____

YEAR OF POSTGRADUATE TRAINING: ☐ PGY1 ☐ PGY2 ☐ PGY3 ☐ PGY4 ☐ PGY5 ☐ PGY6 ☐ OTHER: _____

SECTION 3. SELECT DC ROTATING HOSPITAL

ROTATIONS MAY NOT EXCEED MORE THAN 120 DAYS.

- ☐ CHILDREN'S NATIONAL MEDICAL CENTER ☐ MEDSTAR GEORGETOWN UNIVERSITY HOSPITAL ☐ PROVIDENCE HOSPITAL
☐ GEORGE WASHINGTON UNIVERSITY HOSPITAL ☐ MEDSTAR NATIONAL REHABILITATION HOSPITAL ☐ ST. ELIZABETH'S HOSPITAL
☐ HOWARD UNIVERSITY HOSPITAL ☐ MEDSTAR WASHINGTON HOSPITAL CENTER ☐ UNITY HEALTH CARE
☐ SIBLEY HOSPITAL

DATES OF ROTATION: START DATE: ____/____/____ END DATE: ____/____/____

SECTION 4. AFFIDAVIT

I hereby attest that I am in good academic standing at my current residency training institution 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.

REGISTRANT SIGNATURE

PRINT NAME

DATE

PRINT THIS REGISTRANT FORM AND MAIL TO THE DC BOARD OF MEDICINE. PLEASE RETAIN A COPY FOR YOUR FILES.

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.