

PLEASE TYPE

Supplemental Residency Training Application
Department of Ophthalmology
The University of Texas Southwestern Medical Center at Dallas
Southwestern Medical School - Affiliated Hospitals
Parkland Memorial Hospital
Dallas Veterans Affairs Hospital - Children's Medical Center
John Peter Smith Hospital

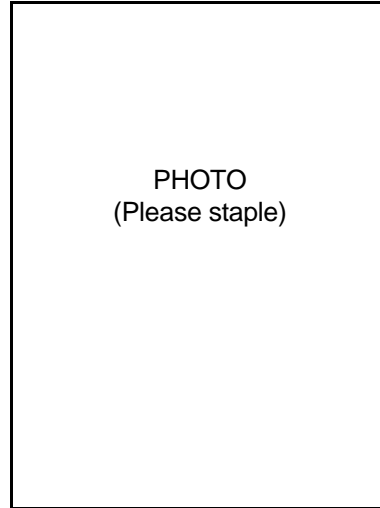
Please return one copy of application to:

FeLisa McDowell, Education Coordinator
 Department of Ophthalmology
 The University of Texas Southwestern Medical
 Center at Dallas
 5323 Harry Hines Blvd.
 Dallas, Texas 75390-9057

Telephone inquiries: (214) 648-3848
 Fax Information: (214) 645-9048

Additional requirements:
 Central Application Service Application
 (www.sfmach.org)

Also attach one copy of your curriculum vitae (CV) to this application.



Deadline: October 1

Residency in: **OPHTHALMOLOGY** OMP#: _____

Name _____ Date of Birth _____

Present Address _____ Telephone _____

STREET

Sex: M F

CITY STATE ZIP
 Permanent Address _____ Telephone _____

STREET

_____ Soc. Sec. No. _____

CITY

STATE

ZIP

Marital Status _____ Spouse's name _____

Military Status _____ Country of Citizenship _____

City & Country of Birth _____ Visa Status _____

PLEASE SEND COPY OF VISA

Do you have any chronic illness or physical or mental disability that would adversely affect your ability to carry out the duties of an ophthalmology resident? _____

Signature _____ Date _____