OKLAHOMA STATE UNIVERSITY CENTER FOR HEALTH SCIENCES   
COLLEGE OF OSTEOPATHIC MEDICINE

**OSTEOPATHIC MANIPULATIVE MEDICINE DEPARTMENT (OMM)**

**1111 West 17th Street, Tulsa, OK 74107**

# NMM/OMM PLUS-ONE RESIDENCY APPLICATION

**Personal Information:**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Name/Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AOA Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Address:**

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_

Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home/Alternate Address:**

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

Country: \_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Military Obligation:**

Are you committed to fulfill a U.S. Military active duty service obligation (Y=Yes, N=No): \_\_\_\_\_\_\_\_\_\_\_

If YES, Years of Commitment: \_\_\_\_\_\_\_\_\_\_ Start Date (Month/Year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Board Eligible/Board Certified (Circle)**

**Specialty:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Board Examination Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your Medical License ever been suspended/revoked/voluntarily terminated?**

(Y=Yes, N=No): \_\_\_\_\_\_\_\_\_\_ If YES, please provide explanation separately.

**Have you ever been named in a malpractice case?** (Y=Yes, N=No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, please provide explanation separately.

**Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?** (Y=Yes, N=No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, please provide explanation separately.

**Have you ever been convicted of a felony?** (Y=Yes, N=No): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, please provide explanation:

**Examinations:** For each examination you have taken, please provide the following information:

|  |  |  |
| --- | --- | --- |
| **COMLEX I** | **COMLEX II** | **COMLEX III** |
| Score: | Score: | Score: |
| Passed on: | Passed on: | Passed on: |
| Failed on | Failed on | Failed on |
| Awaiting results from | Awaiting results from | Awaiting results from |
| Will take on | Will take on | Will take on |
| Will retake on | Will retake on | Will retake on |
| **USMLE I** | **USMLE II** | **USMLE III** |
| Score: | Score: | Score: |
| Passed on | Passed on | Passed on |
| Failed on | Failed on | Failed on |
| Awaiting results from | Awaiting results from | Awaiting results from |
| Will take on | Will take on | Will take on |
| Will retake on | Will retake on | Will retake on |

**All Applicants**

Are you able to carry out the responsibilities of a resident in Neuromusculoskeletal Medicine/ Osteopathic Manipulative Medicine for which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?

**(Y=Yes, N=No): \_\_\_\_\_\_\_\_**

**If NO, please provide explanation separately.**

**Please Attach:**

* Curriculum vitae, which is to include:
  + Contact information
  + Education history (including undergraduate college(s), any graduate education, medical school(s), and residency(ies))
    - Please explain on separate sheet if the course of any of these programs were not completed
  + Work experience
  + Current or past state licenses
  + Board certifications or eligibility
  + Current or past hospital privileges
  + Certifications in ACLS, BLS, PALS, etc
  + CME courses and/or conferences attended
  + Research experience and publications
  + Awards and accomplishments
  + Leadership, volunteer, and extracurricular activities
  + Language fluency in addition to English
* Personal statement (to include personal strengths and reasons for interest in this residency)

**Please Send:**

* Medical school transcripts (send directly to OSU-COM)
* Three letters of recommendation (at least one from a D.O.), including a letter from a previous program director

By submitting this form to a postdoctoral training program, I attest that the information I have provided on this form is true and accurate to the best of my knowledge. I understand that the post-doctoral training programs may seek proof or verification from me or third parties of the information provided on this form. I further understand and acknowledge that providing false information on this form is unethical and would constitute cause for my immediate termination from any training program that offers a position to me.

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Signed Date

**Applications accepted beginning July 1**

**Interviews begin after September 1**

**Anticipated end of interviews January 15**

Return Completed Application to:

Mark Thai, D.O.

OSU-CHS / OMM DEPARTMENT

1111 West 17th Street

Tulsa, OK 74107  
[mark.thai@okstate.edu](mailto:mark.thai@okstate.edu)

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