

Twin Cities Campus

*Department of Therapeutic
Radiology-Radiation Oncology*

*Mayo Mail Code 494
420 Delaware Street S.E
Minneapolis, MN 55455-0385*

Medical School

Office at M26 Masonic

*Medical Physics Residency Program in Radiation Oncology Physics
Clinic located at Fairview-University Medical Center*

*(612) 626-6146 (Office)
(612) 625-5445 (Fax)*

APPLICATION FOR ADMISSION

Type or print responses to the following information:

Personal Information

Name _____
Last
First
Middle
Maiden

Social Security Number (optional) _____

Present Mailing Address _____
Street
City/State/Zip
Until What Date?

Permanent Address (if different) _____
Street
City/State/Zip

Present Telephone Number: (____) _____

Permanent Telephone Number: (____) _____

E-mail Address: _____

Date of Birth _____
 (Optional)

Criminal History

Have you ever been convicted of a crime? _____ Yes _____ No

If yes, please explain on a separate sheet of paper.

Education

College, university or other post-graduate schools attended:

Name of School	City and State	Degree	Year Awarded	Major Field of Study

Employment History

List all employment (begin with most recent employer). Use additional pages if necessary.

<u>Employer/Address</u>	<u>Type of Work</u>	<u>Dates</u>
1. _____		
2. _____		
3. _____		

References

List three professional references. (Please have the letters sent to the Medical Physics Residency Program by deadline listed in Resident Position Description and Availability document).

<u>Name</u>	<u>Department/Position</u>	<u>Institution</u>
1. _____		
2. _____		
3. _____		

Waiver of Access to Reference Statements

Under the Family Educational and Privacy Rights Act, 20 U.S. C. 1232(g), you may, but are not required to waive your right of access to confidential references given in connection with this application. If you waive your right of access, the waiver remains valid indefinitely. Check the appropriate space below:

- _____ I do waive my right of access
- _____ I do not waive my right of access

Signature _____ Date _____

Please provide a letter of intent detailing your interests and goals for this medical physics training program.

Please Read Carefully Before Signing:

The responses given above are true and correct. I understand that any omissions of fact or any false or misleading statements will be considered just cause for dismissal from the program. I agree that all former employers or former faculty with whom I have been associated may furnish the University of Minnesota, Department of Therapeutic Radiology-Radiation Oncology with all information regarding my character and qualifications, and I release all such employers and faculty from any liability for providing such information in good faith

I understand that this application will become inactive after one year.

I understand that I am responsible to have my official transcript(s) of grades from prior undergraduate and graduate academic institutions and letters of reference forwarded (by each school and person giving reference) directly to:

Bruce J. Gerbi, Ph.D.
 Associate Professor and Director, Radiation Physics Section
 Department of Therapeutic Radiology-Radiation Oncology
 Fairview University Medical Center
 420 Delaware St. SE, Mayo Mail Code 494
 Minneapolis, MN 55455

Signature of Applicant _____ Date _____

The University of Minnesota is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regards to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation.

Privacy Statement

All information on this form is private. It will be used to identify and communicate with you, and to determine your qualifications for admission to this program. All items requested on the form are required to process your application, except for those identified as optional (social security number and date of birth). Failure to provide the optional items will have no effect on you application, however, if you are accepted into the program, you must provide a social security number in order to receive a paycheck. Those who may gain access to the information in your file are staff and faculty at the University who have a need to know the information to perform their job responsibilities, and outside organization and government bodies in limited circumstances as authorized by state or federal law. In addition, you may review your own file. No one else may review your file without your written consent or a subpoena or court order.