



Dr. Scott Heinrich
Program Director

Rush University Emergency Medicine Residency Program

Disclosures

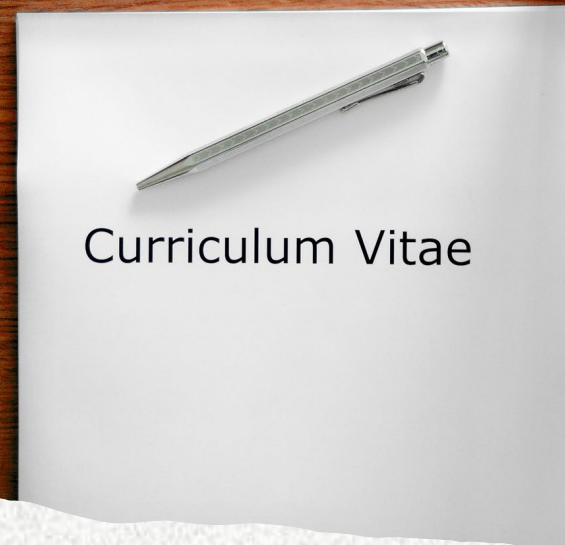
- I have NO financial disclosure or conflicts of interest with the material presented in this presentation



Objectives



- Timeline
- What to prepare
- Resources





Welcome to residency

STATE OF ILLINOIS


 

Medical and Physician License

Name _____ COMPANY NAME _____

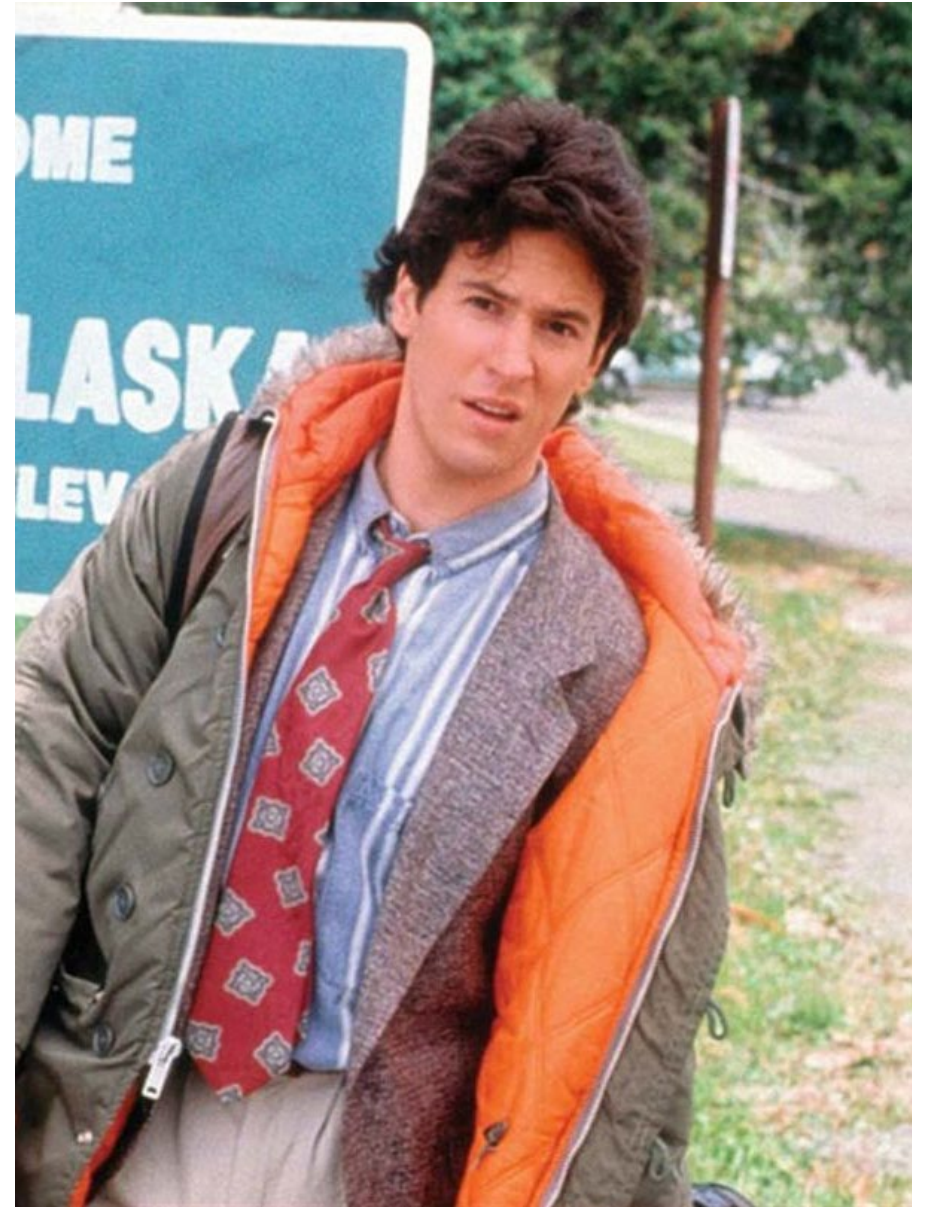
License No _____ XX-00000-XX _____

Expiration _____ 00/00/0000 _____











NOTE: THIS FORM: requires completion in entirety by applicant for licensure under 2600.02(a)(1) in accordance with Tennessee medical licensure regulations. Completion of this document is required for the applicant to be considered for licensure under 2600.02(a)(1) in accordance with Tennessee medical licensure regulations.		CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING		SUPPORTING DOCUMENT TN-MED <small>(10)</small>	
APPLICANT: Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.					
1. NAME: (a) FIRST (b) LAST (c) MIDDLE		2. DATE OF BIRTH: (a) MONTH (b) DAY (c) YEAR		3. SOCIAL SECURITY NUMBER: (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)	
4. ADDRESS (PRINT): CITY, STATE, ZIP CODE		5. STATE TO WHICH YOU WERE LICENSED: (a) ALABAMA (b) ALASKA (c) ARIZONA (d) ARKANSAS (e) CALIFORNIA (f) COLORADO (g) CONNECTICUT (h) DELAWARE (i) DISTRICT OF COLUMBIA (j) FLORIDA (k) GEORGIA (l) HAWAII (m) ILLINOIS (n) INDIANA (o) IOWA (p) KANSAS (q) KENTUCKY (r) LOUISIANA (s) MAINE (t) MARYLAND (u) MASSACHUSETTS (v) MICHIGAN (w) MINNESOTA (x) MISSISSIPPI (y) MISSOURI (z) MONTANA (aa) NEBRASKA (ab) NEVADA (ac) NEW HAMPSHIRE (ad) NEW JERSEY (ae) NEW MEXICO (af) NEW YORK (ag) NORTH CAROLINA (ah) NORTH DAKOTA (ai) OHIO (aj) OKLAHOMA (ak) OREGON (al) PENNSYLVANIA (am) RHODE ISLAND (an) SOUTH CAROLINA (ao) SOUTH DAKOTA (ap) TENNESSEE (aq) TEXAS (ar) UTAH (as) VERMONT (at) VIRGINIA (au) WASHINGTON (av) WEST VIRGINIA (aw) WISCONSIN (ax) WYOMING (ay)			
6. NUMBER OF YEARS (SINCE):		7. CLINICAL TRAINING PROGRAM DIRECTOR'S SIGNATURE:			
8. SIGNATURE DATE:		9. SIGNATURE DATE:			

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.	
This is to certify that the above named applicant satisfactorily completed _____ months of postgraduate clinical training in _____ (General Internal Medicine)	
From _____ (a) MONTH (b) DAY (c) YEAR to _____ (a) MONTH (b) DAY (c) YEAR at the following hospital:	
Hospital: _____	
Number and Street: _____	
City, State and Zip Code: _____	
I further certify that at the time of such training the program was accredited by:	
<input type="checkbox"/> by ACCME	<input type="checkbox"/> by CPSC, PCFPC or IFMAC (Consider Program)
<input type="checkbox"/> by ACG	<input type="checkbox"/> not accredited by either entity
Name of Postgraduate Clinical Training Program Director: _____	
Signature of Postgraduate Clinical Training Program Director: _____	
Date of this Certification: _____	
Telephone: _____	

(If needed, attach letter on letterhead stating actual dates)

1-800-755-7444 (TN)





















FOLLOW-UP

AFTER THE
JOB
INTERVIEW





The mountain of paperwork
on my desk makes me envy
the trees that died to
produce it.





EM Job Search

Career Planning

Job Search

5 Factors for EM Physicians
to Consider When Choosing
Where to Practice

7 Questions to Ask in an EM
Physician Interview

How to Find the Right EM Job

Locum Tenens for EM
Physicians

EM Job Search Resources

Job Search

- [HOW TO FIND THE RIGHT EM JOB](#)
- [LOCUM TENENS FOR EM PHYSICIANS](#)
- [7 QUESTIONS TO ASK IN AN EM PHYSICIAN INTERVIEW](#)
- [5 FACTORS FOR EM PHYSICIANS TO CONSIDER WHEN CHOOSING WHERE TO PRACTICE](#)



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JOB POSTINGS

