



**Post-Appointment Information**  
**Mayo School of Graduate Medical Education**

Date Completed <i>(Month DD, YYYY)</i>
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**Instructions:** The following information is required to begin your appointment at Mayo Clinic. **Complete all three pages on-line, print and return with your signed appointment letter and completed application for residency permit and licensure eligibility questionnaire.**

Full Legal Name as it Appears on Your Social Security Card or Passport <i>(First, Middle, Last)</i>		Preferred or nickname to appear on Mayo Clinic identification card (Bob rather than Robert)	
Current Address			
City		State	ZIP Code
Country			
Contact Phone	Email (non-school email address)		
U.S. Social Security Number		Birth Date <i>(Month DD, YYYY)</i>	
Birth State		Birth Country	
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated		
Spouse/Life Partner Name		Spouse/Life Partner Email	
(Notification for "Making The Move" workshop for spouses and life partners)			

<b>I am a:</b> <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Permanent Resident <input type="checkbox"/> Non-Resident Authorized to Work <input type="checkbox"/> J-1 Visa Holder <input type="checkbox"/> H1-B Visa Holder
If not a U.S. Citizen, specify your country of citizenship.

**International Medical Graduates**

ECFMG Number	Issue Date <i>(Month DD, YYYY)</i>
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**Emergency Contact Information**

Name <i>(First, Middle, Last)</i>		
Address		
City		State
ZIP Code		
Phone	Relationship to You	

Account for **all of your time from medical school graduation date to the beginning of your appointment at Mayo Clinic, this includes any vacation or time off between each appointment/employment.** This information is required for auditing and Medicare purposes. All days must be accounted for, **no exceptions. Exact dates must be provided (MM/DD/YY).** If gaps are found and/or exact dates are not provided, you will be contacted to provide this information before starting your training at Mayo Clinic. If necessary, print additional pages for completion.

<b>Medical School Graduation Date</b>			
Month/Day/Year – Date Indicated on Medical Diploma			
<b>Print clearly and legibly</b>			
<b>Appointment Dates</b>	<b>Appointment/Employer</b>	<b>Institution Name, Program</b>	
<th style="text-align: center;">thru</th> <hr style="width: 50px; display: inline-block; margin-right: 20px;"/> <hr style="width: 50px; display: inline-block;"/>	thru	(e.g., graduate student, resident/ intern, research, employment, vacation, moving)	Institution Name
	Program Name (Surgery, Internal Medicine, etc.)		
	City		
	State (Country)		
<th style="text-align: center;">thru</th> <hr style="width: 50px; display: inline-block; margin-right: 20px;"/> <hr style="width: 50px; display: inline-block;"/>	thru	(e.g., graduate student, resident/ intern, research, employment, vacation, moving)	Institution Name
	Program Name (Surgery, Internal Medicine, etc.)		
	City		
	State (Country)		
<th style="text-align: center;">thru</th> <hr style="width: 50px; display: inline-block; margin-right: 20px;"/> <hr style="width: 50px; display: inline-block;"/>	thru	(e.g., graduate student, resident/ intern, research, employment, vacation, moving)	Institution Name
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	City		
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<th style="text-align: center;">thru</th> <hr style="width: 50px; display: inline-block; margin-right: 20px;"/> <hr style="width: 50px; display: inline-block;"/>	thru	(e.g., graduate student, resident/ intern, research, employment, vacation, moving)	Institution Name
	Program Name (Surgery, Internal Medicine, etc.)		
	City		
	State (Country)		
<th style="text-align: center;">thru</th> <hr style="width: 50px; display: inline-block; margin-right: 20px;"/> <hr style="width: 50px; display: inline-block;"/>	thru	(e.g., graduate student, resident/ intern, research, employment, vacation, moving)	Institution Name
	Program Name (Surgery, Internal Medicine, etc.)		
	City		
	State (Country)		
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	Program Name (Surgery, Internal Medicine, etc.)		
	City		
	State (Country)		



# Race and Ethnicity Questionnaire

## Mayo School of Graduate Medical Education

Mayo Clinic is an equal opportunity employer and educator. We are committed to developing a diverse research and clinical workforce. The information requested is confidential and will not be used to identify any specific individual.

Name (First, Middle, Last)	Date (Month DD, YYYY)
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**Question 1. What is your ethnicity? Select Hispanic/Latino or Non-Hispanic/Latino.**

<input type="checkbox"/> <i>Hispanic or Latino</i> A person of Spanish culture or origin, regardless of race.	If you selected Hispanic or Latino, select one or more of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Central American</li> <li><input type="checkbox"/> Cuban</li> <li><input type="checkbox"/> Mexican – Mexican American or Chicano/Chicana</li> <li><input type="checkbox"/> Puerto Rican</li> <li><input type="checkbox"/> South American</li> <li><input type="checkbox"/> Other Spanish Culture or origin regardless of race (specify): _____</li> </ul>
<input type="checkbox"/> <i>Non-Hispanic/Latino</i>	

**Question 2. What is your race? Select one or more races from the following five major racial groups.**

An individual whose ethnicity is Hispanic can also select a race from the options below as defined in this questionnaire.

<input type="checkbox"/> 1. <i>American Indian or Alaskan Native</i>	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Specify tribe/community: _____
<input type="checkbox"/> 2. <i>Asian</i>	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. Select one or more of the following <ul style="list-style-type: none"> <li><input type="checkbox"/> Cambodian                      <input type="checkbox"/> Laotian</li> <li><input type="checkbox"/> Chinese                            <input type="checkbox"/> Pakistani</li> <li><input type="checkbox"/> Filipino                            <input type="checkbox"/> Taiwanese</li> <li><input type="checkbox"/> Indian                                <input type="checkbox"/> Thai</li> <li><input type="checkbox"/> Japanese                          <input type="checkbox"/> Vietnamese</li> <li><input type="checkbox"/> Korean                             <input type="checkbox"/> Other Asian (specify): _____</li> </ul>
<input type="checkbox"/> 3. <i>Native Hawaiian or US Pacific Islander</i>	A person having origins in any of the original peoples of Hawaii or the US Pacific Islands. Select one or more of the following <ul style="list-style-type: none"> <li><input type="checkbox"/> Hawaiian</li> <li><input type="checkbox"/> Guamanian or Chamorro</li> <li><input type="checkbox"/> Samoan</li> <li><input type="checkbox"/> Other US Pacific Islander (specify): _____</li> </ul>
<input type="checkbox"/> 4. <i>Black/African American</i>	A person having origins in any of the black racial groups of Africa. Inclusive of "Haitians" and groups of Afro-Caribbean descent. Select one or more of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> African American</li> <li><input type="checkbox"/> American Born African</li> <li><input type="checkbox"/> African</li> <li><input type="checkbox"/> Caribbean Black</li> <li><input type="checkbox"/> Other Black (specify) _____</li> </ul>
<input type="checkbox"/> 5. <i>White</i>	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
<input type="checkbox"/> 6. <i>Other</i>	

The completion of this form is optional. Indicate below if you prefer not to complete the form.

I elect not to provide my race and ethnicity to Mayo Clinic.