

# Medical University of the Americas

## ALUMNI INFORMATION FORM

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
M.

\_\_\_\_\_  
Street

\_\_\_\_\_  
Apt. No.

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
MD Graduation Date

Permission to release email Yes ? No ?    Permission to release phone number Yes ? No ?

Specialty _____
Hospital _____
City & State _____
Start Date _____ End Date _____
Present Position _____

Specialty _____
Hospital _____
City & State _____
Start Date _____ End Date _____
Present Position _____

<u>Temporary License to Practice Medicine</u>
_____
State _____
_____
State _____

<u>Chief Resident, Fellowships or Awards</u>
_____
_____

<u>Permanent License to Practice Medicine</u>
_____
State _____
_____
State _____
_____
State _____

<u>USMLE</u>
USMLE Step I    Yes ?    No ?    Score _____
USMLE Step II    Yes ?    No ?    Score _____
USMLE Step III    Yes ?    No ?    Score _____

Date form is being updated: \_\_\_\_\_