

COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)

Applicant Information Form

CONTACT INFORMATION

Name:		Date:
Position:		
Organization:		
Business Address:		
City:	State:	ZIP Code:
Phone:	Fax:	Email:
Home Address:		
City:	State:	ZIP Code:
Phone (opt):	Fax (opt):	Email (opt):

APPLICANT SPECIFIC INFORMATION

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a U.S. Citizen?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth:	Place of Birth:
Race/Ethnicity <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White/Non-Hispanic <input type="checkbox"/> Other (specify): _____	
Geographic Area of Representation: <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural	

VACANCY INFORMATION

The COGME is currently seeking nominees that can represent the following categories:

- Practicing Primary Care Physicians
- Specialty Physician Organizations
- Foreign Medical Graduates
- Medical Student Associations
- Schools of Osteopathic Medicine
- Private Teaching Hospitals
- Health Insurers
- Business

Please check the category or categories that best represents you and your qualifications.

PAST COMMITTEE INVOLVMENT

Are you now serving on any advisory committee for the Health Resources and Services Administration (HRSA)?
 Yes No
If "yes", which committee(s): _____

Have you served on any advisory committee for HRSA within the past 12 years?
 Yes No
If "yes", which committee(s) and when: _____

NOTES

Please include your CV with this Applicant Information Form

For additional information on the COGME contact Shane Rogers at 301-443-5260 or srogers@hrsa.gov