



SCHOOL OF  
OSTEOPATHIC  
MEDICINE

University of Medicine & Dentistry of New Jersey

Graduate Medical Education  
Phone: (856) 566-7121  
Fax: (856) 566-6222

One Medical Center Dr.  
Academic Center Suite 162  
Stratford, NJ 08084-1501

Osteopathic Postdoctoral  
Training Institution  
Phone: (856) 566-7121  
Fax: (856) 566-6222

Dear Doctor:

Attached is an application for residency and fellowship programs. This application is used for the UMDNJ-SOM OPTI Residency and Fellowship Programs at Kennedy Memorial Hospitals-University Medical Center/Our Lady of Lourdes Medical Center and the Family Medicine Residency Program at Christ Hospital. For application materials for the Pediatrics Residency Program at Children's Regional Hospital at Cooper Hospital-University Medical Center, please call (856) 757-7904.

Please submit all information to the Program Director's office. Application deadline for program year 2009-2010 is April 1<sup>st</sup>, 2008. To be considered for the cardiology fellowship program, please send the following to 3001 Chapel Avenue Cherry Hill New Jersey 08002 Suite 101 Attn: Kate Jurman, Program Coordinator:

1. Completed application (typed or printed legibly in black ink) With typed personal statement
2. Official medical school and undergraduate transcripts (original, not copies)
3. Part I, II, and III Board scores
4. Three (3) current letters of recommendation
5. Copy of contract from internship year
6. Copy of internship and/or residency certificates
7. Copy of any / all state license (if applicable)
8. Copy of the CDS and DEA certifications/ ALCS, BLS Certifications/ Current CV
9. Copy of Medical School Diploma

Should you have any questions, please call the Program Director's Assistant at the number listed on the accompanying pages.

Sincerely,

Carl Mogil, D.O., FACOS, FAOAO  
Assistant Dean, Graduate Medical Education

Terry Brown, M.A.  
Director, Graduate Medical Education

***P.S. Visit us on the web at <http://som.umdj.edu>***

TB  
7/06

## RESIDENCY PROGRAM DIRECTORS

For information on a specific residency program, including rotation details and deadline dates, please contact the residency program at the number listed. Completed applications should be sent directly to the residency program.

### EMERGENCY MEDICINE

Anthony J. DiPasquale, D.O.  
Department of Emergency Medicine  
Administrative Office  
18 East Laurel Road  
Stratford, NJ 08084  
Attn: Susan Riser  
(856) 346-7985  
(856) 346-6573 {Fax}

### FAMILY MEDICINE

#### Kennedy Memorial Hospitals-UMC

Allen Clowers, D.O.  
42 E. Laurel Road, Suite 2100 A  
Stratford, NJ 08084  
Attn: Lora Donia  
(856) 566-6085  
(856) 566-6360 {Fax}

### FAMILY MEDICINE

#### Christ Hospital

Shari Fine, D.O.  
324 Palisades Ave.  
Jersey City, NJ 07307  
Attn: Marilynn Gaeta  
(201) 656-3597  
(201) 656-9247 {Fax}

### GENERAL SURGERY

Marc Rosen, D.O.  
42 East Laurel Road  
Suite 2600  
Stratford, NJ 08084  
Attn: Mary Guglielmo  
(856) 566-6875  
(856) 566-6873 {Fax}

### INTERNAL MEDICINE-

Traditional  
James C. Giudice, D.O.  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Karen Welding  
(856) 566-6288  
(856) 566-6952 {Fax}

### INTERNAL MEDICINE-

Primary Track  
Joanne Kaiser-Smith, D.O.  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Willa Peters  
(856) 566-6288  
(856) 566-6952 {Fax}

### OBSTETRICS/GYNECOLOGY

Ronald Ayers, D.O.  
42 East Laurel Road  
Suite 3200  
Stratford, NJ 08084  
Attn: Naomi Spina  
(856) 566-7098  
(857) 566-6499 {Fax}

### ORTHOPEDIC SURGERY

Carl Mogil, D.O.  
42 East Laurel Road  
Suite 3900  
Stratford, NJ 08084  
Attn:  
(856) 566-6835  
(856) 566-6222 {Fax}

### OTORHINOLARYNGOLOGY

Edward D. Scheiner, D.O.  
1924 East Route 70  
Cherry Hill, NJ 08003  
Attn: Linda Hendrickson  
(856) 424-9200  
(856) 424-9245 {Fax}

### PSYCHIATRY

Glenn Zielinski, D.O.  
2250 Chapel Avenue  
Suite 100  
Cherry Hill, NJ 08002  
Attn: Elaine Evans  
(856) 482-9000  
(856) 482-1159 {Fax}

### UROLOGY

Jerome Pietras, D.O.  
205 East Laurel Road  
Stratford, NJ 08084  
Attn: Kathy Pietras  
(856) 783-5500  
(856) 783-5706 {Fax}

### INTERNAL MEDICINE/EMERGENCY MEDICINE (IM/EM)

(Must send application to both Directors)

Thomas Morley, D.O. (Int Med Portion)  
Department of Internal Medicine  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Karen Welding  
(856) 566-6859  
(856) 566-6952 {Fax}

Victor Scali, D.O. (Emer Med Portion)  
Department of Emergency Medicine  
Administrative Office  
18 East Laurel Road  
Stratford, NJ 08084  
Attn: Susan Riser  
(856) 346-7985  
(856) 346-6573 {Fax}

## FELLOWSHIP PROGRAM DIRECTORS

For information on a specific fellowship program, including rotation details and deadline dates, please contact the fellowship program at the number listed. Completed applications should be sent directly to the fellowship program.

### CARDIOLOGY

John Hamaty, D.O.  
3001 W. Chapel Avenue  
Suite 101  
Cherry Hill, NJ 08002  
Attn: Kate Jurman  
(856) 755-1173  
(856)667-6588 {Fax}

### CHILD/ADOLESCENT PSYCHIATRY

Mark Sacher, D.O. (apptmnt. 11/04)  
2250 Chapel Avenue West  
Suite 100  
Cherry Hill, NJ 08002  
Attn: Elaine Evans  
(856) 482-9000  
(856) 482-1159 {Fax}

### CRITICAL CARE

Thomas Morely, D.O.  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Karen Welding  
(856) 566-6859  
(856) 566-6952 {Fax}

### GASTROENTEROLOGY

Andrew Alloy, D.O.  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Carol Maguire  
(856) 566-6853  
(856) 566-6342 {Fax}

### GERIATRICS (Family Medicine track)

Gintare Gecys, D.O.  
42 East Laurel Road  
Suite 1800  
Stratford, NJ 08084  
Attn: Pam Basehore  
(856) 566-6470  
(856) 566-6419 {Fax}

### GERIATRICS (Internal Medicine track)

Thomas Cavalieri, D.O.  
42 East Laurel Road  
Suite 1800  
Stratford, NJ 08084  
Attn: Pam Basehore  
(856) 566-6470  
(856) 566-6419 {Fax}

### INFECTIOUS DISEASES

David Condoluci, D.O.  
Glendale Executive Campus  
1000 White Horse Road  
Suite 608  
Voorhees, NJ 08043  
Attn: Kelly Rand  
(856) 566-3190  
(856) 566-1903 {Fax}

### NEPHROLOGY

Joseph Pitone, D.O.  
201 Laurel Oak Road  
Voorhees, NJ 08043  
Attn: Lynda Dunn  
(856) 566-5478  
(856) 566-9561 {Fax}

### ONCOLOGY

Nathan Freed, D.O.  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Karen Welding  
(856) 566-2753  
(856) 566-6952 {Fax}

### PULMONARY

James Giudice, D.O.  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Karen Welding  
(856) 566-6859  
(856) 566-6952 {Fax}

### VASCULAR SURGERY

Charles Dietzek, D.O.  
42 East Laurel Road  
Suite 2600  
Stratford, NJ 08084  
Attn: Mary Guglielmo  
(856) 566-6875  
(856) 566-6873 {Fax}

### New Program 7/06 Endocrinology

Louis Haenel, D.O.  
42 East Laurel Road  
Suite 3100  
Stratford, NJ 08084  
Attn: Laurie Scullion  
(856) 566-6859  
(856) 566-6952 {Fax}

**APPLICATION FOR RESIDENCY/FELLOWSHIP TRAINING**

**UMDNJ-School of Osteopathic Medicine**

**Osteopathic Postdoctoral Training Institution**

Application for Residency/Fellowship in \_\_\_\_\_

For Post Graduate Year (i.e., PGY 2, 3) \_\_\_\_\_ beginning July, \_\_\_\_\_

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK.

Name \_\_\_\_\_  
(Last) (First) (Middle)

Social Security No. \_\_\_\_\_ AOA No. \_\_\_\_\_

Present Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Permanent Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Check preferred mailing address as listed above: \_\_\_\_\_ Present Address \_\_\_\_\_ Permanent Address

Phone where you can be reached during the day: (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Address \_\_\_\_\_

Phone: Day (\_\_\_\_\_) \_\_\_\_\_ Night (\_\_\_\_\_) \_\_\_\_\_

Are you a: \_\_\_\_\_ U.S. Citizen? \_\_\_\_\_ Permanent Resident? \_\_\_\_\_ Other?\*

\*If other, please provide documentation for eligibility to be employed in the U.S.

References: List the names, titles and addresses of three references.

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_

Pre-Professional Education: List, in order, Colleges or Universities you have attended.

<u>Name of College</u>	<u>Location</u>	<u>Dates of Attendance</u>	<u>Degree and Date</u>
_____	_____	_____	_____
_____	_____	_____	_____

Professional Education: List medical school(s) you attended.

<u>Name of Medical School</u>	<u>Location</u>	<u>Dates of Attendance</u>	<u>Degree and Date</u>
_____	_____	_____	_____
_____	_____	_____	_____

Post-Graduate Education:

Internship: Track \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Institution \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Residency: Specialty \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Institution \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Hospital Affiliations: List Hospital names, locations and dates of Hospital staff appointments.

\_\_\_\_\_  
\_\_\_\_\_

Present Membership in Organizations: List professional, scientific, etc.

\_\_\_\_\_  
\_\_\_\_\_

Research or Practical Experience: Include Publications, if any.

\_\_\_\_\_  
\_\_\_\_\_

National Board of Osteopathic Medical Examiners board scores:

Part I \_\_\_\_\_ Date of Examination \_\_\_\_\_

Part II \_\_\_\_\_ Date of Examination \_\_\_\_\_

Part III \_\_\_\_\_ Date of Examination \_\_\_\_\_

Do you plan on taking the USMLE? \_\_\_\_\_ No \_\_\_\_\_ Yes, Date of Exam \_\_\_\_\_

New Jersey License Number \_\_\_\_\_

Please attach copy of New Jersey license.

Has your New Jersey license ever been suspended or revoked?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

New Jersey CDS Number \_\_\_\_\_

Has your New Jersey CDS certificate ever been suspended or revoked?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Federal DEA Registration Number \_\_\_\_\_

Has your Federal DEA certificate ever been suspended or revoked?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Do you have a license to practice medicine in any other state(s)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list states, dates and license numbers.

<u>State</u>	<u>Dates</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____

Have you ever been involved in a malpractice suit?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give the date and nature of case(s) and status of the suit, i.e., open, dismissed, closed with payment.

<u>Date</u>	<u>Nature of Case</u>
_____	_____
_____	_____

Discuss your plans after you finish your residency/fellowship program. Include practice location, if known.

Please use the space below to amplify upon your biographic data with any information that you think would be helpful in the evaluation of your application.

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(Applicant's Signature)

---

(Date)

---

(Print Name)

**UMDNJ does not discriminate in admissions or access to its programs and activities on the basis of race/color, national origin, ethnicity, religion/creed, disability, age, marital status, sex, sexual orientation or veteran's status.**

**Appointment to this position requires that you are not listed by the Office of Inspector General (OIG) and/or the General Services Administration (GSA) as excluded from participating in federal health care, research, or other grant programs.**

**UMDNJ-School of Osteopathic Medicine**

**Osteopathic Postdoctoral Training Institution**

**AUTHORIZATION FOR RELEASE OF INFORMATION AND**

**RELEASE FROM CIVIL LIABILITY**

I specifically authorize the University and its authorized representatives to consult with the management and members of the medical staffs of other hospitals, health care facilities, previous colleges/universities and/or other institutions with which I have been associated and with others who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter. This University or its authorized representatives may inquire and inspect all records and documents that may be material to the above.

I hereby release from civil liability any individual or institution reviewing or providing information relative to my application for residency/fellowship at UMDNJ-SOM OPTI.

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(Applicant's Signature)

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(Date)

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(Print Name)