

6 Provide a chronological list of all activities **since graduation from professional school to the present**. Include residency, employment and vacation periods. Be sure there are **no gaps in time** from the **ending date of one activity** to the **beginning date of the next activity**. **Any gap in time will cause a delay in the processing of your application.** Attach additional sheets if necessary.

Graduation Date from Medical School: _____ / _____
Month Year

1. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

2. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

3. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

4. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

5. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

6. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

7. Beginning _____ / _____ Ending _____ / _____ Type of activity Residency Employment Vacation
month year month year (if residency or employment, fill out name and address below)

Name of Employer/Facility _____

Address _____
Street City State ZIP Code

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Unit, 89 Washington Avenue, Albany, NY 12234-1000.