South Miami Hospital
BAPTIST HEALTH SOUTH FLORIDA

Residency Candidate Application

Name: _____
Last First MI

Address: _____

_____

_____

Phone Number: (_____) _____

Email Address: _____

College of Pharmacy: _____

Date of Graduation: _____

National Matching Service ID Number: _____

Work Authorization/Licensure:

- Are you authorized to work in the United States? Yes No (Circle One)
  If yes, please check the appropriate box:

  ☐ US Citizen ☐ Permanent US Resident ☐ Other _____

- Are you licensed to practice pharmacy in the United States? _____

  If yes - State: _____ License #: _____ Year Licensed: _____

Signature: _____ Date: _____