Application for Fellowship

Name of Subspecialty Program:	
Starting Date:	

Personal Information:

Last Name:	
First Name:	
Middle Initial:	**Previous Last Name:**
Date of Birth:	**Birthplace:**
Present Mailing Address:	
Permanent Mailing Address:	
Preferred Phone number:	
Email:	
Citizenship:	☐ **US Citizen** ☐ **Permanent Resident** ☐ **Conditional Permanent Resident** ☐ **Foreign National**
Current and Expected Visa Types: (for Foreign Nationals only) **VISA Type** (J1, H1, F1, etc.)	
Other:	

Education: For each examination you have taken, please provide the requested information (copies of ECFMG and USMLE must be included)

Premedical College:	**Degree:**	**Month/Year Completed:**
Medical School:	**Degree:**	**Month/Year Completed:**

International Medical Graduates: Are you certified by the Educational Commission for Foreign Medical Graduates? YES or NO

Month______________ **Year**_____________ **USMLE/ECFMG ID:** __________________ **NBOME ID:**________________

Previous Training

Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? YES or NO
If yes, please explain and provide a letter from the program director.
Have you ever failed to complete or been terminated by a postgraduate training program? YES or NO
If yes, please explain

For each internship, residency, or fellowship position you have held or currently are in, regardless of the amount of time spent there, please provide the requested information. This worksheet has space for you to make 2 entries. Attach additional worksheets as needed.

1. Specialty: ____

Type of Training: ☐ Internship ☐ Residency ☐ Fellowship
Institution/Program: ____
Country: __________________________ State/Province: _____________________
City: ____
Years: _____
Program Director: ____
Supervisor: ____
Dates of Internship/Residency/Fellowship:
From: Month/Year: ___________ To: Month/Year: ___________
Reason for leaving:

2. Specialty: ____

Type of Training: O Internship O Residency O Fellowship
Institution/Program: ____
Country: __________________________ State/Province: _____________________
City: ____
Years: _____
Program Director: ____
Supervisor: ____
Dates of Internship/Residency/Fellowship:
From: Month/Year: ___________ To: Month/Year: ___________
Reason for leaving

Medical Licensure

STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE:		
State:	**License#:**	**Expiration Date:**
State:	**License#:**	**Expiration Date:**

Has your Medical License ever been suspended/revoked/voluntarily terminated or denied? YES ☐ NO ☐

If yes, please explain.

Have you ever been named in a malpractice case? YES ☐ NO ☐

If yes, please explain.

Is there anything in your history that would limit your ability to be licensed or to receive hospital privileges?
YES ☐ NO ☐

If yes, please explain.

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, please explain.

Are you Board Certified? YES ☐ NO ☐

Board Name:

☐ I am ACLS (Advanced Cardiac Life Support) certified in the U.S.A. Expiration Date: __________

☐ I am BLS (Basic Life Support) certified in the U.S.A. Expiration Date: __________

☐ I am PALS (Pediatric Advanced Life Support) certified in the U.S.A. Expiration Date: __________

Are you committed to fulfill U.S. Military active duty service obligations/deferments? YES ☐ NO ☐
If Yes:

Years: __________

Branch: __________

Do you have any other service obligations? (i.e. Military Reserves or Public Health/State programs) YES ☐ NO ☐

If yes, please provide Description on separate page (up to 255 characters)

References: Please list the names and institutions of three physicians who will be writing letters for you: (Name, Title and Institution)

1.
2.
3.

I certify that the information contained within this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position, or if employed, may constitute cause for termination from the program.

________________________________ ________________________

Signature Date

____

Name of Applicant – Type or Print