NEUROLOGY FELLOWSHIP APPLICATION

PAGE ONE

PROGRAM YOU ARE APPLYING FOR	**(Program Name)**	**(Starting Year)**

NAME: **(LAST)** **(FIRST)** **(MIDDLE)**

1. NAME (LAST) (FIRST) (MIDDLE) **2. SOCIAL SECURITY NUMBER** - -

3. PLACE OF BIRTH: **DATE OF BIRTH** **4. CITIZENSHIP** IF NOT U.S. IMMIGRATION STATUS, TYPE OF VISA:

MEDICAL EDUCATION/PGY RESIDENCY EDUCATION

5. RESIDENCY PROGRAM/HOSPITAL

DIPLOMA EARNED: MONTH/YEAR OF GRADUATION

PROGRAM DIRECTOR: CONTACT PHONE NUMBER FOR PROGRAM:

6. MEDICAL SCHOOL(S) (NAME)

(CITY) (STATE/COUNTRY)

DEGREE EARNED: MONTH/YEAR OF GRADUATION

GRADUATE EDUCATION

7. GRADUATE SCHOOL(S)	DATES ATTENDED FROM (MO/YR)	DATES ATTENDED TO (MO/YR)	GRADUATE DEGREE (IF ANY)	AREA OF STUDY
A. NAME				
CITY STATE				
B. NAME				
CITY STATE				

UNDERGRADUATE EDUCATION

8. UNDERGRADUATE SCHOOL(S)	DATES ATTENDED FROM (MO/YR)	DATES ATTENDED TO (MO/YR)	DEGREE (IF ANY)	MAJOR
A. NAME				
CITY STATE				
B. NAME				
CITY STATE				
C. NAME				
CITY STATE				

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9. SERVICE OBLIGATIONS (NATIONAL HEALTH SERVICE CORPS, ARMED FORCES SCHOLARSHIP, STATE PROGRAMS, ETC.)

☐ I AM NOT REQUIRED TO FULFILL ANY SERVICE OBLIGATIONS

☐ I AM COMMITTED TO FULFILL A SERVICE OBLIGATION BEGINNING _____ **(MO/YEAR)**

NUMBER OF YEARS COMMITTED ☐

ADDITIONAL EMPLOYMENT/HOSPITAL EXPERIENCES

10. INSTITUTION/FACILITY	DATES FROM (MO/YR)	DATES TO (MO/YR)	DEPARTMENT	POSITION
A. NAME				
CITY STATE				
B. NAME				
CITY STATE				
C. NAME				
CITY STATE				

LICENSES/ORGANIZATIONS

11. LICENSE/MEMBERSHIP	LICENSE # MEMBERSHIP #	CITY/STATE	CREDENTIALING/EXAM INFO.
A. NAME			
CITY STATE			
B. NAME			
CITY STATE			
C. NAME			
CITY STATE			

12. PLEASE ANSWER THE FOLLOWING QUESTIONS; IF THE ANSWER TO ANY OF THE QUESTIONS IS YES, A DETAILED REPORT CLARIFYING THE SITUATION MUST ACCOMPANY THIS APPLICATION.

A.	HAS ANY LICENSE ENTITLE YOU TO PRACTICE MEDICINE AND/OR SURGERY IN ANY JURISDICTION BEEN REFUSED, SUSPENDED OR REVOKED?	☐ YES	☐ NO
B.	HAS YOUR DEA CERTIFICATE EVER BEEN REFUSED, SUSPENDED OR REVOKED?	☐ YES	☐ NO
C.	HAVE YOU EVER BEEN DENIED MEMBERSHIP OR BEEN SUBJECT TO DISCIPLINARY PROCEEDINGS IN ANY MEDICAL ORGANIZATION?	☐ YES	☐ NO
D.	HAVE YOU EVER BEEN SUSPENDED OR REMOVED INVOLUNTARILY FROM A HOSPITAL OR ANY INSTITUTION'S MEDICAL STAFF?	☐ YES	☐ NO
E.	DO YOU HAVE A CHRONIC OR RECURRING ILLNESS, OR A MAJOR PHYSICAL OR MENTAL DISABILITY THAT MIGHT LIMIT YOUR ABILITY TO PRACTICE YOUR SPECIALTY?	☐ YES	☐ NO
F.	ARE YOU NOW AN ALCOHOLIC AND/OR HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM?	☐ YES	☐ NO
G.	ARE YOU NOW ADDICTED TO DRUGS AND/OR HAVE YOU EVER BEEN CONVICTED OR TREATED FOR DRUG ADDICTION?	☐ YES	☐ NO
H.	HAVE YOU EVER BEEN CONVICTED OF A FELONY?	☐ YES	☐ NO
I.	HAVE YOU EVER HAD MALPRACTICE OR LIABILITY INSURANCE COVERAGE SUSPENDED OR DENIED?	☐ YES	☐ NO
J.	HAVE ANY CLAIMS BEEN ASSERTED AGAINST YOU ALLEGING PROFESSIONAL MALPRACTICE BEFORE ANY MEDICAL LEGAL PANEL OR A COURT OF LAW?	☐ YES	☐ NO

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13. NAME (LAST) (FIRST) (MIDDLE)

ATTACH RECENT PHOTOGRAPH

14. VQE/ DATE/ LOCATION/ CLINICAL SCORE

15. ECFMG Registration (if applicable)

16. FMGEMS/ LOCATION/ CLINICAL SCORE

17. NRMP CODE (enter "pending" if unknown)

18. PRESENT ADDRESS (STREET)

(CITY) (STATE/ZIP) (COUNTRY)

PRESENT PHONE NOS.

DAY ( ) EVENING ( )

19. NUMBER OF DEPENDENTS

20. VISA STATUS (IF APPLICABLE)

☐ PERMANENT ☐ J-1

☐ TEMPORARY - SPECIFY: ☐ H-1

21. CITIZENSHIP

☐ U.S. ☐ OTHER

22. PERMANENT ADDRESS: (STREET)

C/O (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED)

(CITY) (STATE/ZIP) (COUNTRY) PERMANENT PHONE NO. ( )

23. I HAVE ALREADY PASSED THE EXAMINATIONS CHECKED BELOW ON THE DATES INDICATED:

☐ NBME, PART I: _____ (SCORE/DATE) ☐ NBME, PART II: _____ (SCORE/DATE) ☐ NBME, PART III: _____ (SCORE/DATE)

☐ USMLE, PART I: _____ (SCORE/DATE) ☐ USMLE, PART II: _____ (SCORE/DATE) ☐ USMLE, PART III: _____ (SCORE/DATE)

☐ FLEX: _____ (SCORE/DATE) _____ (STATE(s) of licensure)

LIST ANY ADDITIONAL EXAMINATIONS PASSED (FMGEMS, DAY 1; FMGEMS, DAY 2; VQE, DAY 1; VQE, DAY 2; ECFMG MEDICAL SCIENCE EXAM):

_____

24. INTERVIEW SCHEDULING

☐ THE FOLLOWING GENERAL TIME PERIOD IS MOST CONVENIENT FOR ME: FROM: _____ TO: _____

☐ I AM ABLE TO SCHEDULE AN INTERVIEW ON THE FOLLOWING SPECIFIC DATE(s):

_____ (DATE) _____ (DATE) _____ (DATE) _____ (DATE)

☐ I AM NOT ABLE TO COME FOR AN INTERVIEW

25. I HAVE READ AND I UNDERSTAND THE INSTRUCTIONS FOR THE COMPLETION OF THIS APPLICATION. I CERTIFY THAT THE INFORMATION SUBMITTED ON THESE APPLICATION MATERIALS IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THIS POSITION.

SIGNATURE OF APPLICANT: _____ DATE: _____

NOTE: THE SIGNATURE AND DATE ON EACH APPLICATION MUST BE ORIGINAL.

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26. LETTERS OF REFERENCE, IN ADDITION TO THE DEAN'S/CHAIR'S LETTER, HAVE BEEN REQUESTED FROM THE FOLLOWING INDIVIDUALS:

A. NAME AND TITLE

INSTITUTION

ADDRESS

B. NAME AND TITLE

INSTITUTION

ADDRESS

C. NAME AND TITLE

INSTITUTION

ADDRESS

D. NAME AND TITLE

INSTITUTION

ADDRESS

27. (CHECK ONE)

☐ I HEREBY WAIVE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS.

☐ I DESIRE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS.

SIGNATURE _____ DATE: _____

NAME OF APPLICANT - TYPE OR PRINT _____

YOUR APPLICATION **MUST** INCLUDE:

- ☐ CURRICULUM VITAE (CV) – SEND ELECTRONICALLY
- ☐ PERSONAL STATEMENT / LETTER OF INTEREST
- ☐ COPY OF MEDICAL SCHOOL DIPLOMA
- ☐ MEDICAL SCHOOL TRANSCRIPT
- ☐ 3 LETTERS OF REFERENCE (LORs)
- ☐ LETTER OF GOOD STANDING FROM CURRENT/PAST RESIDENCY PROGRAM DIRECTOR
- ☐ USMLE/COMLEX SCORES (Step I, Step II, Step II CS, Step III)
- ☐ ECFMG CERTIFICATE (IF APPLICABLE)
- ☐ DIGITAL PHOTO – SEND ELECTRONICALLY