

NEUROLOGY FELLOWSHIP APPLICATION

PAGE ONE

PROGRAM YOU ARE APPLYING FOR				NAME: (LAST) (FIRST) (MIDDLE)
(Program Name)			(Starting Year)	
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		GRADUATE DEGREE	AREA OF STUDY
	FROM	TO	(IF ANY)	
	(MO/YR)	(MO/YR)		
A. NAME				
CITY		STATE		
B. NAME				
CITY		STATE		
UNDERGRADUATE EDUCATION				
8. UNDERGRADUATE SCHOOL(S)	DATES ATTENDED		DEGREE	MAJOR
	FROM	TO	(IF ANY)	
	(MO/YR)	(MO/YR)		
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		DEPARTMENT	POSITION
	FROM (MO/YR)	TO (MO/YR)		
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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
B.	HAS YOUR DEA CERTIFICATE EVER BEEN REFUSED, SUSPENDED OR REVOKED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
C.	HAVE YOU EVER BEEN DENIED MEMBERSHIP OR BEEN SUBJECT TO DISCIPLINARY PROCEEDINGS IN ANY MEDICAL ORGANIZATION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
D.	HAVE YOU EVER BEEN SUSPENDED OR REMOVED INVOLUNTARILY FROM A HOSPITAL OR ANY INSTITUTION'S MEDICAL STAFF?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
F.	ARE YOU NOW AN ALCOHOLIC AND/OR HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
G.	ARE YOU NOW ADDICTED TO DRUGS AND/OR HAVE YOU EVER BEEN CONVICTED OR TREATED FOR DRUG ADDICTION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
H.	HAVE YOU EVER BEEN CONVICTED OF A FELONY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I.	HAVE YOU EVER HAD MALPRACTICE OR LIABILITY INSURANCE COVERAGE SUSPENDED OR DENIED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
J.	HAVE ANY CLAIMS BEEN ASSERTED AGAINST YOU ALLEGING PROFESSIONAL MALPRACTICE BEFORE ANY MEDICAL LEGAL PANEL OR A COURT OF LAW?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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13. NAME (LAST) (FIRST) (MIDDLE)		<div style="border: 1px dashed black; padding: 20px; text-align: center;"> ATTACH RECENT PHOTOGRAPH </div>
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) <input type="checkbox"/> PERMANENT <input type="checkbox"/> J-1 <input type="checkbox"/> TEMPORARY - SPECIFY: <input type="checkbox"/> H-1	
21. CITIZENSHIP <input type="checkbox"/> U.S. <input type="checkbox"/> 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:		
<input type="checkbox"/> NBME, PART I: _____ (SCORE/DATE)	<input type="checkbox"/> NBME, PART II: _____ (SCORE/DATE)	<input type="checkbox"/> NBME, PART III: _____ (SCORE/DATE)
<input type="checkbox"/> USMLE, PART I: _____ (SCORE/DATE)	<input type="checkbox"/> USMLE, PART II: _____ (SCORE/DATE)	<input type="checkbox"/> USMLE, PART III: _____ (SCORE/DATE)
<input type="checkbox"/> 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	
<input type="checkbox"/> THE FOLLOWING GENERAL TIME PERIOD IS MOST CONVENIENT FOR ME: FROM: _____ TO: _____	
<input type="checkbox"/> I AM ABLE TO SCHEDULE AN INTERVIEW ON THE FOLLOWING SPECIFIC DATE(s): _____ (DATE) _____ (DATE) _____ (DATE) _____ (DATE)	
<input type="checkbox"/> 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: _____	
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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