NEUROLOGY FELLOWSHIP APPLICATION

Year you are applying to:______________________________ Circle one: PGY 1 2 3 4 5 6 7

Indicate the specialty to which you are applying ____

1. PERSONAL DATA:

Name in full ____
First Middle Last

Current mailing address ____
Street City State

_____________ Telephone:___________ ______________________________
Zip Code area code

Permanent address if different from current ____
Street City State Zip Code

Place of Birth ____ Date of Birth______________________________

Social Security Number _______________ (if you do not have a Social Security number, one must be obtained before reporting for duty as resident.)

Are you a U.S. citizen? Yes/No If no, current status or visa ____

2. EDUCATION

Medical School ____
Name Degree

____
Location (City and State) Date or (Date Expected)

List chronologically your activities from the time of graduation from Medical School to present. Specify type of post-graduate training, if any.

FROM	TO	ACTIVITY	PLACE	DEGREE, IF ANY

(If additional space is required, please use separate sheet of paper)

3. EXPERIENCE

Special Clinical and/or Research experience ____

____

____

Professional practice, location and dates ____

____

Memberships in professional societies and list any publications ____

____

(Use separate sheet of paper if needed)

4. MEDICAL LICENSURE AND CERTIFICATION (if applicable)

Date and Results of National Boards Examinations or F.L.E.X. (please include copy of results)

____

Attach copies of all State Licenses issued to you.

Have you ever had an application for medical licensure denied? ______________________________. If so, state the date, circumstances, and State where your application was denied.

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Have you ever had a medical license revoked? ____________________. If so, state date, circumstances and State where the license was revoked. ____

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Since your sixteenth birthday, have you ever been convicted of a felonious offense or are there felony charges currently pending against you? ______________________

If so, indicate as to the court involved, nature of offense, disposition or current status of the case and date of case.

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5. FOREIGN MEDICAL SCHOOL GRADUATES ONLY

Citizenship and Date ____ (if not U.S. Citizen,

type of Visa) ____. If on a J.1 exchange

visitors visa, give country ______________________________. Please provide ECFMG certificate

number and date issued: ______________________________

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6. **A minimum of three letters of Reference is required: (One should be from the Dean of your medical School; and two from physicians who have observed you or supervised you in recent training programs. If you have had previous post-graduate training, one letter must be from your former program director).**

List below the names of your three references and ask them to correspond to submit letters of recommendation to umneurofellowships@med.miami.edu.

1. ____
Name Email Address or Contact Number
2. ____
Name Email Address or Contact Number
3. ____
Name Email Address or Contact Number

Any Others:

____
Name Contact info:

____
Name Contact info:

7 **AGREEMENT**

If I am offered an appointment by the Public Health Trust to serve at the University of Miami/Jackson Memorial Hospital Medical Center and I accept same, I will abide by all the Rules and Regulations of the included Hospitals for members of the House Staff including but not limited to Medical Staff Bylaws, Medical Staff Rules and Regulations , Public Health Trust Policies and Procedures and the Collective Bargaining Agreement between the Public Health Trust and the Committee of Interns and Residents and will to the best of my ability fulfill the obligations of my assignment for the full term of my appointment.

Anticipated Start Date________________________ Anticipated Ending Date________________________

8. **ENCLOSE WITH THE COMPLETED APPLICATION THE FOLLOWING:**

a) Transcript of Medical School Scholastic Record
b) Copy of State Licenses (if applicable)
c) Board Certificate (if applicable)
d) Valid ECFMG Certificate, or ECFMG documentation (if applicable)
e) Curriculum Vitae
f) 3 Letters of Recommendation (1 from PD and 2 from faculty)
g) USMLE scores
h) Medical Diploma
i) Letter of intent/Personal Statement

Please submit application and supporting documentation to umneurofellowships@med.miami.edu