University Hospitals

Neurological Institute

Please attach recent photo

I hereby apply for appointment as a Graduate Medical Trainee at University Hospitals Case Medical Center of Cleveland, Ohio for _____months, beginning _____

PLEASE (√) APPOINTMENT DESIRED

Neurology Residency ( ) Neuromuscular Fellowship ( ) Neurovascular Fellowship ( ) Neurobehavioral Fellowship ( )
Neurocritical Care Fellowship ( ) Other: _____

Full Name: _____ M.D. ____ M.B.B.S. _____ D.D.S. _____

D.O. ____ M.B.B. Ch. ____ D.M.D. _____

DEMOGRAPHICS

Present Address: _____

City: _____State: _____ Zip _____ Country: _____

Telephone: _____ Beeper #: _____

E-Mail Address: _____ Fax #: _____

Permanent Address: _____

City: _____State: _____ Zip _____ Country: _____

Other:

Place of Birth: _____ Date of Birth: _____ Married: ____ Single: _____

Citizen of: _____ U.S. Social Security #: _____

MEDICAL LICENSE

U.S. Unrestricted Medical License (attach copy):

State: _____No. _____

State: _____No. _____

Graduate medical Training License (attach copy):

State: _____ No: _____

State: _____ No: _____

U.S. Licensing Exams passed (attach copy of scores for each exam):

ECFMG English: _____TOEFL _____ Clinical Skills Assessment: ___ LMCC ____ FLEX _____

State Board _____FLEX 1_____FLEX II _____NBME 1 _____ NBME III _____ USMLE 1 _____

USMLE 2 _____ USMLE 3 _____

Medical License/International Medical Graduates: (attach copies of each document)

ECFMG Certificate No. _____ Type of Visa _____ Hold _____ Needed _____

MEDICAL EDUCATION AND TRAINING

Medical Education:

Institution: _____

From :_____ To:_____ Degree:_____

Hospital Training: (Do not list rotations in medical school):

Hospital Location From To Degree

_____

_____

_____

_____

_____

_____

Post Graduate Education:

_____

_____

Special Training (not already listed, such as assistantships, summer work, extra curricular activities practice, etc.)

_____

_____

_____

Board Certification:

Year	Specialty	Name of Board	Country of Issuing Board

Publications & Grants

REFERENCES: Communications concerning professional ability and personal qualifications must be sent under separate cover directly to Kristin Stacy, Department of Neurology at University Hospitals Case Medical Center from at least three (3) physicians, preferably under whom you served or training. **Letters of recommendation must be requested by the applicant.** List references below:

Name	Title	Address	Affiliation

SIGNATURE OF APPLICANT: _____ DATE: _____

Return to:
Attn: Tarrika Allen
HH5040 Department of Neurology
University Hospitals Cleveland Medical Center
11100 Euclid Avenue
Cleveland, OH 44106-5040
216-844-3100 (office #)
216-844-3160 (fax #)