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| Please attach recent photo |



**APPLICATION FOR EPILEPSY FELLOWSHIP**

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am applying for appointment as a fellow at University Hospitals Case Medical Center for one year

beginning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CHECK APPOINTMENT DESIRED

ACGME Accredited Epilepsy Fellow ( )

Requires completion of neurology residency in the U.S.A. or Canada

Non-ACGME Accredited Epilepsy Fellow ( )

Requires completion of neurology residency and USMLEs.

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL LICENSE and EXAMINATIONS**

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

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_

USMLEs Scores (attach copy of scores for each exam):

Step 1: \_\_\_\_\_\_\_ Step 2 CK: \_\_\_\_\_\_\_\_ Step 2 CS: \_\_\_\_\_\_\_ Step 3: \_\_\_\_\_\_

**International Medical Graduates:** (attach copies of each document)

ECFMG Certificate No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Visa: Hold \_\_\_\_\_\_\_ Needed \_\_\_\_\_\_\_

**MEDICAL EDUCATION AND TRAINING**

**Medical School**:

Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Residency and Fellowship Training:**

Type Hospital/Location From To

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**Other Education and Training**:

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**Board Certification:**

Name of Board Year Country of Issuing Board

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**Publications:**

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**REFERENCES**: (List your 3 references below and have their recommendation letters sent separately addressed to the program director)

Name Title Address Affiliation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SIGNATURE OF APPLICANT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mail or email the application along with current CV, 3 reference letters, and copies of medical diploma, USMLEs and ECFMG certification (for IMGs) to:**

 **Attn: Tarrika Allen**

**University Hospitals Case Medical Center**

**11100 Euclid Avenue, LKS 6058**

**Cleveland, OH 44106-5040**

**Email:** **Tarrika.allen@UHhospitals.org**