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

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):

Graduate medical Training License (attach copy):

State: _____ No. _____

State: _____ No: _____

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 (or equivalent) Certification :

Year Specialty Name of Board Country of Issuing Certification

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: Kristin Stacy, C-TAGME**
Bashar Katirji, MD, FACP,
Director, Neuromuscular Center & EMG laboratory
HH5040 Department of Neurology
University Hospitals Case Medical Center
11100 Euclid Avenue
Cleveland, OH 44106-5040