 KPCOM GME Fellowship Application

***Insert Recent Photo of Applicant Here***

**ACADEMIC YEAR TO BEGIN FELLOWSHIP**

|  |  |
| --- | --- |
|  | 2023-24 |

|  |  |
| --- | --- |
|  | 2024-25 |

|  |  |
| --- | --- |
|  | 2025-26 |

**PERSONAL DATA:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | |  | | | | |  |
| Last Name | | | | | | | | First Name | | | | | Middle Initial |
|  | | | | | | | | | | | | | |
| Present Address | | | | | | | | | | | | | |
|  | | | | | |  | | |  | | |  | |
| City | | | | | | State | | | Zip Code | | | Country | |
| ( ) | | | | | ( ) | | | | | | ( ) | | |
| Home Phone | | | | | Work Phone | | | | | | Cell Phone | | |
|  | | | | | | | | | | | | | |
| Email Address | | | | | | | | | | | | | |
|  | | | | |  | | | | | |  | | |
|  | | | | |  | | | | | |  | | |
| Citizen of U.S. |  | Yes |  | No | | | Social Security Number | | |  | | | |
|  | | | | | | | | | | | | | |

**EDUCATION:**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| College or University | City/State | Dates | Degree |
|  |  |  |  |
| College or University | City/State | Dates | Degree |
|  |  |  |  |
| College or University | City/State | Dates | Degree |
|  |  |  |  |
| Advanced Degree School | City/State | Dates | Degree |
|  |  |  |  |
| Advanced Degree School | City/State | Dates | Degree |
|  |  |  |  |
| Medical School | City/State | Dates | Degree (MD/DO) |

**GRADUATE MEDICAL EDUCATION**:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PGY-I** | **HOSPITAL** | **CITY:**   |  | | --- | |  |   **STATE:**   |  | | --- | |  | | **DATES** (INCLUSIVE) | **TYPE** |
| **RESIDENCY** | **HOSPITAL** | **CITY**:   |  | | --- | |  |   **STATE**:   |  | | --- | |  | | **DATES** (INCLUSIVE) | **TYPE** |
| **RESIDENCY** | **HOSPITAL** | **CITY**:   |  | | --- | |  |   **STATE**:   |  | | --- | |  | | **DATES** (INCLUSIVE) | **TYPE** |

**US MEDICAL LICENSE EXAMINERS** (copy of original required):

\*\* Include all scores whether passing or non-passing.

\*\* Submit FLEX, NBME or COMLEX scores, if applicable.

|  |  |  |
| --- | --- | --- |
| **I- date** | **II-date** | **III-date** |

PREVIOUS PRACTICE EXPERIENCE:

|  |
| --- |
|  |

PREVIOUS ROTATION IN AREA OF FELLOWSHIP (Dates, Type, Location, Instructor):

|  |
| --- |
|  |

OTHER PREVIOUS EXPERIENCE IN AREA OF FELLOWSHIP

(If Sports Medicine include: Games, Events, Training Room, Other):

|  |
| --- |
|  |

PREVIOUS COCNFERENCES ATTENDED IN AREA OF FELLOWSHIP:

|  |
| --- |
| Attended: |
| Presented: *PLEASE INCLUDE A COPY OF THE PROGRAM OF ANY LISTED PRESENTATION* |

PUBLICATIONS (author, title, publication, date – use additional sheets if necessary): *PLEASE INCLUDE A COPY OF THE TITLE PAGE OF ANY LISTED PUBLICATION.*

|  |
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|  |

ADDITIONAL PERSONAL DATA:

1. Work Experience Prior to Medical Training (Occupation/Title, Dates):

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| --- |
|  |

2. Military Status (U.S.A.) (Present Status and Service):

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
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|  | |  |  | |  |  | |  |
| a. Do you hold a reserve Commission? | |  | Yes | |  | No | |  |
|  |  |
|  |  |
| To begin: |  | | | for |  | | on |  |

|  |  |
| --- | --- |
| Branch: |  |
| Rank: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| b. Have you served in the military or USPHS? |  | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you attended summer training camp? |  | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| c. Are you required to attend reserve meetings? |  | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are you required to attend summer training camp? |  | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| d. Do you have a military or USPHS Commitment? |  | Yes |  | No |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| To begin: |  | for |  | on |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 3. Are you certified by the E.C.F.M.G.? | | | | |  | Yes | |  | No | |  |
|  |  |
| Which qualifying exam taken? | |  | | | | | | | | | |
| a. Dates passed: |  | | | | | | | |  | |  |
| b. Scores | Part I: | |  | | | | Part II: | | |  | |
| c. Certificate Number: |  | | | | | | | | | | |
| d. Certificate valid through what date: | | | |  | | | | | | | |

|  |  |  |
| --- | --- | --- |
| 4. If not a U.S. Citizen, will you enter or remain in the U.S. on: | | |
| a. Exchange Visitor Visa: |  | |
| b. Permanent Visa Number: |  | |
| c. How many years may you remain in the U.S.A.? | |  |

5. Conferences Attended or Presented (other than in area of fellowship):

|  |
| --- |
|  |

6. Honors and Awards:

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| --- |
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7. Have you ever been placed on probation, suspended from your job duties, residency, training program, had privileges revoked, or been part of a malpractice complaint? □

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| --- | --- | --- | --- | --- | --- |
|  | Yes |  |  | No | If YES, please explain below. |

8. Are you aware of any limitation which would prevent you from performing the duties of the fellowship for which you are applying?

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| --- |
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9. Personal Statement: (please do not exceed 750 words)

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10. References and Supporting Documents:

**\*Please ask three physicians who have supervised you in a clinical setting to send letters in support of your application.**

**\*Copies of the following documents are requested: medical school diploma, certificate or other validation of all previous training, copy of present state medical licenses, and curriculum vitae.**

\*Please note that individual fellowships may require additional information such as letter of commendation from medical school dean, undergraduate and medical school transcripts, and rotations taken during residency. *Contact the individual fellowships you are applying to for further application requirements and deadlines.*



**DO NOT SEND ORIGINAL DOCUMENTS. NO DOCUMENTS WILL BE RETURNED.**

PHOTOCOPIES OF THIS APPLICATION WILL BE ACCEPTED. HOWEVER THE SIGNATURE ON EACH HARD COPY APPLICATION MUST BE ORIGINAL

I certify that the information given or attached is true, accurate and complete. Be advised, any inaccuracies within this application could disqualify your candidacy.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature: |  |  | Date: |  | |
|  | (Signature must be original on hard copies) |  |  | |  |

|  |  |
| --- | --- |
|  | Check here to verify electronic signature |

**PLEASE SEND ALL APPLICATIONS AND SUPPORTING DOCUMENTS TO THE NSU-KPCOM OFFICE OF GRADUATE MEDICAL EDUCATION AT:**

|  |
| --- |
| **Nova Southeastern University**  **Tampa Bay Regional Campus**  **3400 Gulf to Bay Blvd.**  **ATTN: Dr. Les Ross, Room 3606**  **Clearwater, FL 33759** |
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