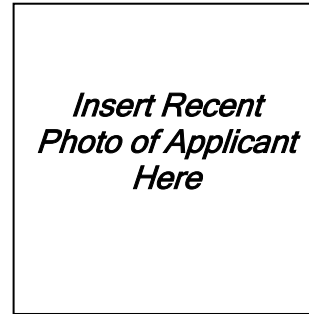


ACADEMIC YEAR TO BEGIN FELLOWSHIP

- 2020-21
- 2021-22
- 2022-23



PERSONAL DATA:

Last Name	First Name	Middle Initial
Present Address		
City ()	State ()	Zip Code ()
Home Phone	Work Phone	Country
Email Address		
Citizen of U.S. <input type="checkbox"/> Yes <input type="checkbox"/> 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:	DATES (INCLUSIVE)	TYPE
		STATE:		

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
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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: <i>PLEASE INCLUDE A COPY OF THE PROGRAM OF ANY LISTED PRESENTATION</i>

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

ADDITIONAL PERSONAL DATA:

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

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

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

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:

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?

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?

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

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: _____
(Signature must be original on hard copies)

Date: _____

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 Dr. Kiran C. Patel College of Osteopathic Medicine
3200 South University Drive
HPD Terry Building, Room 1489
Attn: Kristopher Lalji
Ft. Lauderdale, FL 33328
Kl437@nova.edu
954-262-1547**