DIVISION OF IMMUNOLOGY
DEPARTMENT OF INTERNAL MEDICINE
UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE

Application for Fellowship Training

YEAR FELLOWSHIP TO BEGIN____

NAME__________________________SOCIAL SECURITY NO.____________________

ADDRESS____

______________________________________TELEPHONE____________________

U.S. CITIZEN YES___ NO___ (IF NO, LIST VISA STATUS____________________)

EDUCATION

MEDICAL SCHOOL______________________________Degree and Year____________

INTERNSHIP____
(Name of Hospital) (Location) (Inclusive Dates)

RESIDENCY____
(Name of Hospital) (Location) (Inclusive Dates)

FELLOWSHIPS____
(Name of Hospital) (Location) (Inclusive Dates)

OTHER TRAINING____
(Institution) (Location) (Inclusive Dates)

IF FOREIGN GRADUATE: VQE Status____

ECFMG Number ____
Valid Visa Number ____
Certificate Number ____

USMLE / FLEX EXAMINATIONS

____
(Date) (Level) (Results / Score)

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(Date) (Level) (Results / Score)

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(Date) (Level) (Results / Score)

MEDICAL LICENSES

State__________________Year____

State__________________Year____

PREVIOUS RESEARCH EXPERIENCE______________________________________

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PUBLICATIONS____

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REFERENCES: Please have three (3) letters of recommendations sent directly.

1. Dean of your Medical School plus class standing (copy of your transcript is satisfactory)

2. One member of the Department of Internal Medicine of your hospital

3. One member of your Hospital Medical Staff under whom you have had internship or residency training

When will it be possible for you to come to Cincinnati for an interview?____________________________

Please indicate your goals for fellowship training and your plans after completing training.

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SIGNATURE____DATE________________________________

Completed form should be returned to:

L. Shakeith Graber, Program Coordinator
Division of Immunology
University of Cincinnati College of Medicine
PO Box 670563
Cincinnati, Ohio 45267-0563