

DEPARTMENT OF INTERNAL MEDICINE - FELLOWSHIP APPLICATION

Virginia Commonwealth University Medical College of Virginia Campus

Please attach a
recent photograph

Approximately
2" x 2"

Applying for year: _____
SUBSPECIALTY (Check one):

- | | |
|---|--|
| <input type="checkbox"/> ADDICTION MEDICINE | <input type="checkbox"/> GENERAL INTERNAL MEDICINE |
| <input type="checkbox"/> ALLERGY & IMMUNOLOGY | <input type="checkbox"/> GERIATRICS |
| <input type="checkbox"/> CARDIOLOGY | <input type="checkbox"/> HEMATOLOGY/ONCOLOGY |
| <input type="checkbox"/> CARDIOLOGY/ELECTROPHYSIOLOGY | <input type="checkbox"/> INFECTIOUS DISEASES |
| <input type="checkbox"/> CARDIOLOGY/INTERVENTIONAL | <input type="checkbox"/> NEPHROLOGY |
| <input type="checkbox"/> ENDOCRINOLOGY/METABOLISM | <input type="checkbox"/> PULMONARY & CRITICAL CARE |
| <input type="checkbox"/> GASTROENTEROLOGY | <input type="checkbox"/> RHEUMATOLOGY |

1. Print NAME (Last, First, M.I.): _____

2. SOCIAL SECURITY NUMBER: _____

3. DATE OF BIRTH: _____ PLACE OF BIRTH: _____

4. CITIZENSHIP:

- U.S. citizen
- Permanent Resident (green card)
- Non-citizen National (e.g., Puerto Rico, Virgin Islands, Guam, or other US Protectorate)
- J1 Visa holder
- None of the above*

*If you indicated "none of the above," you are not eligible for a fellowship.

5. MAILING ADDRESS: _____

PERMANENT ADDRESS: _____

6. § (Home): _____ § (Hospital): _____ E-Mail: _____

EDUCATIONAL BACKGROUND

10. UNDERGRADUATE & GRADUATE EDUCATION:

SCHOOL	DEGREE	DATES ATTENDED

11. MEDICAL EDUCATION:

SCHOOL	DEGREE	DATES ATTENDED
Date of Graduation (Day/Month/Year):		

12. POST GRADUATE TRAINING:

HOSPITAL	DATES
Internship:	
Residency:	
Fellowship:	

13. LICENSURE:

STATE(S)	NUMBER(S)	Date

14. List any honors received during your pre-medical or medical education. Include societies, medical course honors, awards and scholarships:

15. List any published clinical or research papers, by author, title journal, volume, page and year.

16. Please indicate US Medical Licensing Examination (USMLE) numerical results (2-digit/3-digit):

Part I: ____/____ Part II: ____/____ Part III: ____/____

17. FLEX Exam (if applicable):

Part I: _____ Date: _____ Results: _____
Part II: _____ Date: _____ Results: _____

18. ECFMG certificate # (If applicable): _____

20. Are you a member of the Alpha Omega Alpha medical honor society? Yes _____ No _____

THE INFORMATION CONTAINED IN THIS APPLICATION (AND THE ACCOMPANYING DOCUMENTS) IS ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature: _____ Date: _____

FELLOWSHIP APPLICATION INSTRUCTIONS

1. Complete all sections of this application and return application with photograph.
2. Attach a copy of a current curriculum vitae and a list of publications.
3. An evaluation from your Department Chair or Residency Training Program Director is required for completion of this application. Please identify who will write the letter:

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4. In addition, a minimum of 3 letters of recommendation is required from faculty who have worked closely with you and can comment on your academic, professional and personal performance. Please identify the faculty members who will write these letters:

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5. Have the Dean or Registrar of your medical school forward an official copy of your transcripts.
 6. Personal Statement: Please include a statement (about 250 words) about yourself, your interests, aspirations, etc.

ATTENTION Non-US CITIZENS: IN ADDITION TO THE ABOVE MATERIALS, NON-US CITIZENS MUST ALSO SUBMIT THE FOLLOWING DOCUMENTS:

7. Notarized ECFMG certificate.
8. Copy of Permanent Residency Card or IAP-66 Form (front and back).
9. Copy of notarized medical school diploma and notarized translation, if applicable.

FORWARD APPLICATION & SUPPORTING DOCUMENTS TO THE PROGRAM DIRECTOR OF THE DIVISION TO WHOM YOU ARE APPLYING. FOR ADDITIONAL CONTACT INFORMATION, VISIT OUR WEBSITE AT

<http://views.vcu.edu/internal-medicine/inm/fellowship.html>.