UNIVERSITY of ROCHESTER MEDICAL CENTER

# FACULTY DEVELOPMENT FELLOWSHIP APPLICATION

*Please Print or Type*

**Last Name:**

**First Name:**

**Middle Name:**

**Desired Start Date:** (MM/YYYY)

**Contact Address:**

**Permanent Address:**

| | | |
|---|---|---|
| Home Phone Number: | Preferred Phone ☐ | |
| Work Phone Number: | Preferred Phone ☐ | |
| Cell Phone Number: | Preferred Phone ☐ | |
| Email: | | |
| National Provider Identifier (NPI) Number: | | |
| Date of Birth (MM/DD/YYYY): | | |
| Place of Birth: | | |
| Country of Citizenship: | | |
| For Foreign Nationals: | Current Visa Type: | Requested Visa Type: |
| *Optional:* | | |
| *Ethnicity:* | | |
| *Race:* | | |

**Medical Licensure**

| | |
|---|---|
| Board Certified? | ☐ YES NO |
| If yes, which Board: | |
| If no, do you plan to be? | YES ☐ NO |
| If yes, which Board and when? | |
| Ever Named in a Malpractice Suit? | ☐ YES NO |
| State Medical License? | YES ☐ NO |
| If yes, specify state, number, expiration date: | |
| Are you a diplomate of the National Board of Medical Examiners (NBME)? | ☐ YES NO |
| Have you successfully completed the Federation Licensing Examination (FLEX)? | ☐ YES NO |

**Educational Commission for Foreign Medical Graduates Certification**

| | |
|---|---|
| Are you certified by the ECFMG? | ☐ YES ☐ NO |
| If yes, ECFMG Number and date (MM/YYYY): | |

Note: A copy of your ECFMG certificate is required for credentialing purposes.

**Medical Education**

| Institution & Location | Dates Attended (MM/YYYY – MM/YYYY) | Degree | Degree Date (MM/YYYY) |
|---|---|---|---|
| | | | |

**Education (list all graduate and undergraduate schools; non-medical education only)**

| Education | Institution & Location | Dates Attended (MM/YYYY – MM/YYYY) | Degree | Degree Date (MM/YYYY) | Field of Study |
|---|---|---|---|---|---|
| ☐ Graduate ☐ Undergraduate | | | | | |
| ☐ Graduate ☐Undergraduate | | | | | |
| ☐ Graduate ☐ Undergraduate | | | | | |

**Previous Fellowships**

| Name of Fellowship | Institution & Location | Dates Attended (MM/YYYY – MM/YYYY) |
|---|---|---|
| | | |
| | | |

**Current / Prior Medical Training**

| Specialty / Experience | Institution & Location | Program Director | Dates Attended (MM/YYYY – MM/YYYY) | Years of Training |
|---|---|---|---|---|
| | | | | |

**Student/Faculty Committees (Curriculum Committees, Admissions Committees, etc.)**

| Committee | Institution & Location | Dates (MM/YYYY – MM/YYYY) | Duties |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Program Evaluation Committee | | | |
| Recruitment Committee | | | |
| PhD Oversight Committee | | | |
| Student Advisory Committee | | | |

**Work Experience (list any laboratory, research, or teaching assistant positions held)**

| Position | Hospital / Practice Name | City / State / Zip | Dates (MM/YYYY – MM/YYYY) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Please check any of the following experiences you may have had:**

| | Location | Dates (MM/YYYY – MM/YYYY) |
|---|---|---|
| ☐ Military | | |
| ☐ National Health Service Corps | | |
| ☐ U.S. Public Health Service | | |
| ☐ Peace Corps | | |
| ☐ Other (Specify) | | |

**Briefly describe the nature of the experiences you have checked which you feel are especially pertinent to this fellowship**

**Publications (enclose copies of those which you feel are most relevant)**

**Achievement (List up to four awards, honors, scholarships, etc. in order of perceived importance)**

| Name of Award | Award Citation | Institution | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Other Awards & Accomplishments**

| |
|---|
| |

**Research Experience & Area(s) of Interest**

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|---|
| |

**If public service is of interest to you, please indicate which area(s) is most appealing.**

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|---|
| |

**References (all references must send letters to the Project Director. One must be the Program Director of your most recent clinical training program.)**

| Name | Title | Address |
|---|---|---|
| | | |
| | | |

**Please describe how your clinical experiences influenced your decision to apply for the General Pediatrics Academic Fellowship program. Use only the space provided:**

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|---|
| |

**Objectives** (Please state the reason for your interest in the General Pediatrics Academic Fellowship Program. The Statement must describe your career goals, your research interests, and how these can be accomplished by acceptance into in the General Pediatrics Academic Fellowship Program. You may want to explain how past experiences influenced your decision to apply and mention special areas of interest. Please feel free to respond with a paragraph, a page or two, or an essay. Attach your response to this application, making sure your name Appears on the attachment.)

**I acknowledge by my signature below that a drug test will be a condition of employment.**

APPLICANT SIGNATURE _____ DATE: _____

APPLICANT PRINTED NAME _____

**Please include your CV with this completed application and send to:**

Eileen Tipton
Fellowship Coordinator
Highland Family Medicine
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Fax: (585) 279-4618