

# APPLICATION FOR FELLOWSHIP IN PALLIATIVE MEDICINE

<b>POSITION BEGINNING IN _____</b>					(LAST)
1. NAME (LAST) (FIRST) (MIDDLE)			2. SOCIAL SECURITY NUMBER		
3. I AM APPLYING TO THE FOLLOWING GRADUATE PROGRAM: PROGRAM DESCRIPTION					
4. (FUNDING SITE PREFERRED:* CareCenter; Stroger)		5. CITY	STATE	ZIP	
<b>MEDICAL EDUCATION</b>					
6. MEDICAL SCHOOL(S) (NAME)					
CITY (STATE/COUNTRY)					
7. MONTH/YEAR OF MATRICULATION AT MEDICAL SCHOOL			8. MONTH/YEAR OF (ANTICIPATED) GRADUATION		
9. ELECTIVES COMPLETED/PLANNED (PLACE A "P" AFTER PLANNED SENIOR ELECTIVES)					
10. HONORS/AWARDS					
<b>RESIDENCY EDUCATION</b>					
11.					
RESIDENCY	<u>DATES ATTENDED</u>		GRADUATE DEGREE	AREA OF STUDY	
	FROM	TO	(IF ANY)		
	(MO/YR)	(MO/YR)			
A. NAME					
CITY					
B. NAME					
CITY					
<b>GRADUATE EDUCATION</b>					
12.					
GRADUATE COLLEGE(S)	<u>DATES ATTENDED</u>		DEGREE	AREA OF STUDY	
	FROM	TO	(IF ANY)		
	(MO/YR)	(MO/YR)			
A. NAME					
CITY					
B. NAME					
CITY					
C. NAME					
CITY					

\*CareCenter—Midwest Palliative & Hospice CareCenter  
 Stroger—John H. Stroger, Jr. Hospital of Cook County

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13. PERSONAL STATEMENT (SEE INSTRUCTIONS, USE ADDITIONAL SHEET, IF NECESSARY)

14. SERVICE OBLIGATIONS (NATIONAL HEALTH SERVICE CORPS, ARMED FORCES SCHOLARSHIP, STATE PROGRAMS, ETC.)

I AM NOT REQUIRED TO FULFILL ANY SERVICE OBLIGATIONS

I AM NOT COMMITTED TO FULFILL A SERVICE OBLIGATION

**NUMBER OF YEARS COMMITTED**

MO/YR

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15. NAME (LAST)		(FIRST)	(MIDDLE)	<div style="border: 1px dashed black; padding: 10px;"> <p>ATTACH RECENT PHOTOGRAPH</p> <p><u>OPTIONAL</u> (SEE INSTRUCTIONS)</p> </div>
16. SOCIAL SECURITY NUMBER		17. ECFMG Registration (if applicable)		
18. SHALL PARTICIPATE IN NRMP MATCH		19. NRMP CODE (enter "pending" if unknown)		
20. PRESENT ADDRESS (STREET)				
(CITY)	(STATE)	(ZIP)		
PRESENT PHONE NOS.				
DAY ( )		EVENING ( )		
21. NUMBER OF DEPENDENTS		22. VISA STATUS (IF APPLICABLE)		
23. CITIZENSHIP		<input type="checkbox"/> PERMANENT <input type="checkbox"/> J-1 <input type="checkbox"/> TEMPORARY-SPECIFY: <input type="checkbox"/> H-1		
<input type="checkbox"/> U.S. <input type="checkbox"/> OTHER				
24. PERMANENT ADDRESS: C/O (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED) (STREET)				
(CITY)	(STATE)	(ZIP)	PERMANENT PHONE NO. ( )	

I plan to take the examinations checked below before I begin the Graduate Medical Educational program for which I am now applying:

25.

USMLE, STEP I                       USMLE, STEP II                       USMLE, STEP III

I have already passed the examinations checked below on the dates indicated:

26.

<input type="checkbox"/> NBME, PART I: _____	<input type="checkbox"/> NBME, PART II: _____	<input type="checkbox"/> NBME, PART III: _____
<input type="checkbox"/> USMLE, STEP I: _____	<input type="checkbox"/> USMLE, STEP II: _____	<input type="checkbox"/> USMLE, STEP III: _____
<input type="checkbox"/> FLEX: _____		_____
DATE		(STATE(s) of licensure)

LIST ANY ADDITIONAL EXAMINATIONS PASSED (FMGEMS, DAY 2; VQE, DAY 1; VQE, DAY 2; ECFMG MEDICAL SCIENCE EXAM):

**INTERVIEW SCHEDULING**

27.

THE FOLLOWING GENERAL TIME PERIOD IS MOST CONVENIENT FOR ME: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

I AM ABLE TO SCHEDULE AN INTERVIEW ON THE FOLLOWING SPECIFIC DATES:

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
 (DATE)                                      (DATE)                                      (DATE)                                      (DATE)

I AM NOT ABLE TO COME FOR AN INTERVIEW

I have read and I understand the instructions for the completion of this application. I certify that the information submitted on these application materials is complete and correct to the best of my knowledge: I understand that any false or missing information may disqualify me for this position.

28.

SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_

**NOTE: THE SIGNATURE AND DATE ON EACH APPLICATION MUST BE ORIGINAL**

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LETTERS OF REFERENCE, IN ADDITION TO THE DEAN'S LETTER, HAVE BEEN REQUESTED FROM THE FOLLOWING INDIVIDUALS:	
29. A.	NAME AND TITLE
	INSTITUTION
	ADDRESS
B.	NAME AND TITLE
	INSTITUTION
	ADDRESS
C.	NAME AND TITLE
	INSTITUTION
	ADDRESS
D.	NAME AND TITLE
	INSTITUTION
	ADDRESS

30. (CHECK ONE)

I HEREBY WAIVE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS.

I DESIRE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**NAME OF APPLICANT – TYPE OR PRINT**

NOTE: THE SIGNATURE AND DATE ON THIS STATEMENT MUST BE ORIGINAL.