



APPLICATION FOR FELLOWSHIP IN MATERNAL-FETAL MEDICINE

I. APPLICANT INFORMATION

Last Name:

First Name:

M.I.:

Current Mailing Address:

City:

State:

Zip:

Home #:

Mobile/Pager #:

Email:

DOB:

SSN:

Birth Place:

Gender:

Marital Status:

Citizenship:

Permanent Immigrant Visa #:

J Visa #:

Other:

II. MEDICAL TRAINING

1st RESIDENCY Institution and Location:

Start Date (mm/yyyy)

End Date (mm/yyyy)

CREOG Scores:

1st year

2nd year

3rd year

4th year

MEDICAL SCHOOL PROGRAM

Institution and Location:

Start Date (mm/yyyy)

End Date (mm/yyyy)

Degree Awarded/Year:

2nd RESIDENCY Institution and Location:

Start Date (mm/yyyy)

End Date (mm/yyyy)

USMLE:

Step 1

Step 2 (Clinical Knowledge)

Step 2 (Clinical Skills)

UNDERGRADUATE EDUCATION

Institution and Location:

Start Date (mm/yyyy)

End Date (mm/yyyy)

Degree Awarded/Year:

Area of Study:

III. LICENSURE

State:	License #:	Date Obtained :	Expiration Date:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
State:	License #:	Date Obtained:	Expiration Date:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Standard ECFMG Certificate Number (If you are a Foreign Medical Graduate – Mandatory)		Certification Date:	
<input type="text"/>		<input type="text"/>	

1. Are you a Diplomat of the National Boards? If yes, please provide documentation.
 Yes No
2. Do you have American Board Certification? If yes, please provide documentation.
 Yes No
3. Have you ever been denied a license, permit, or privilege of taking an examination by any licensing authority?
 Yes No
4. Have you ever had a license or permit encumbered in any way (revoked, suspended, surrendered, censored, restricted, limited, placed on probation)? If yes, attach a detailed explanation.
 Yes No
5. Have you ever been named in a malpractice suit? If yes, attach a detailed description.
 Yes No

IV. EMPLOYMENT AND HOSPITAL PRIVILEGES

Institution and Location:	Position:
<input type="text"/>	<input type="text"/>
<input type="text"/>	Dates: <input type="text"/> / <input type="text"/>
Institution and Location:	Position:
<input type="text"/>	<input type="text"/>
<input type="text"/>	Dates: <input type="text"/> / <input type="text"/>

V. HONORS AND AWARDS / PUBLICATIONS / INTERESTS / ACTIVITIES

Honors and Awards:

Publications:

Interests:

Activities:

VI. REFERENCES

** A minimum of three letters of recommendation is required, one of which should be from the Program Director of your residency program.*

Full Name:

Title:

Institution:

Telephone #:

Full Name:

Title:

Institution:

Telephone #:

Full Name:

Title:

Institution:

Telephone #:

VII. CERTIFICATION

I certify that the information contained on this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a fellowship position, or if employed, may constitute cause for termination from the fellowship program.

Applicant's Signature:

Date:

VIII. SUPPORTING DOCUMENTATION

When submitting your application, please include the following:

1. A current curriculum vitae.
2. A personal statement describing your interest in pursuing a fellowship in Maternal-Fetal Medicine and your long-range goals after the fellowship is completed. This may include any specific research or clinical interests, and plans to serve as an Maternal-Fetal Medicine consultant in private practice or academic medicine.
3. A description of your resident research project (minimum of one full page).
4. Three letters of recommendation from professional colleagues, one of which should be from the Program Director of your residency program.
5. Recent photograph (affix at the bottom of the page).
6. Please feel free to submit any additional information that you deem pertinent to your application.

All application materials should be returned no later than August 15th, 2007 to:

Barak M. Rosenn, MD
Director, Maternal Fetal Medicine Fellowship Program
Director, Division of Obstetrics and Maternal-Fetal Medicine
St. Luke's-Roosevelt Hospital Center
Department of Obstetrics and Gynecology
1000 Tenth Avenue, Suite 10-C
New York, NY 10019

Tel: 212 523-6266

Fax: 212 523-8066

Email: Brosenn@chpnet.org

For Internal Use only:

Approved: Rejected:

Signature, Program Director: Barak M. Rosenn, MD

Date:

Signature, Department Chair: Oded Langer, MD, PhD

Date:

Affix
2 x 2"
photo
here