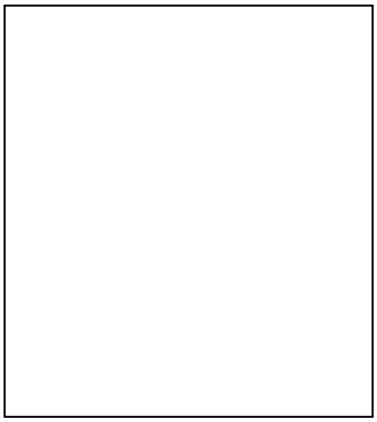

PHOTO: Optional

Grant Medical Center
Department of Medical Education
111. South Grant Avenue
Columbus, OH 43215
Phone: (614) 566-9290
Fax: (614) 566-8073

Date of Application: _____

EQUAL OPPORTUNITY EMPLOYER **PLEASE PRINT OR TYPE IN BLACK INK**

I wish to apply for: **Fellowship**

- ☐ **Breast Surgery**
- ☐ **Colon and Rectal Surgery**
- ☐ **Hospital Medicine**
- ☐ **Orthopaedic Trauma**
- ☐ **Surgical Critical Care**
- ☐ **Ophthalmic Trauma & Emergency**
- ☐ **Trauma Research**

For the following time period: (MM/DD/YY)_____ to (MM/DD/YY) _____

APPLICANT INFORMATION

Last	First	Middle	NPI Number

Mailing Address	City	State	Zip

Home/Cell Phone #	Work Phone #	E-Mail

Other Address	City	State	Zip

Birthplace: City	State	Country	Citizenship

REFERENCES

References should include name, title, complete address and phone number. Please provide a reference letter from your current Residency Program Director, in addition to three other reference letters.

Name	Title	Address	Phone
Name	Title	Address	Phone
Name	Title	Address	Phone

Program Director:	Address	Phone

EDUCATION			
Undergraduate School	Degree	Address	Phone
Medical School	Degree	Address	Phone
Medical School Graduation Date Month Date Year			

RESIDENCY				
PGY 1 Hospital	Address	Phone	Start Date	End Date
PGY 2 Hospital	Address	Phone	Start Date	End Date
PGY 3 Hospital	Address	Phone	Start Date	End Date
PGY 4 Hospital	Address	Phone	Start Date	End Date
PGY 5 Hospital	Address	Phone	Start Date	End Date
Other Hospital	Address	Phone	Start Date	End Date

MEDICAL LICENSURE						
Current Licenses	State	Number	Exp Date	State	Number	Exp Date
DEA						
Have you completed the DATA Waiver training to obtain your X-DEA certification? ___ Yes ___ No						

EXAMINATION					
COMLEX 1 Score	Date	COMLEX 2 Score	Date	COMLEX 3 Score	Date
USMLE 1 Score	Date	USMLE 2 Score	Date	USMLE 3 Score	Date
NBME 1 Score	Date	NBME 2 Score	Date	NBME 3 Score	Date
Other	Date	Other	Date	Other	Date

INTERNATIONAL GRADUATES

OhioHealth Grant Medical Center will consider applicants who are U.S. citizens, lawful permanent residents, asylees and refugees, and other individuals with work authorizations that do not require visa sponsorship by Grant Medical Center.

ECFMG Certificate Number	FMGEMS Score	Date Issued	Expiration Date

Green Card #	Issue Date

Have you ever been convicted of:

1. Misdemeanor Conviction in the United States? ___No ___Yes.
2. Felony Conviction of a felony, sex crime, or misappropriation of funds in the United States? ___No ___Yes
3. Limitations? ___No ___Yes.

PLEASE INCLUDE YOUR PERSONAL STATEMENT AND CURRICULUM VITAE

Authorization and Release:

To the best of my knowledge, the information that I have provided in this application is true and free of any consequential omissions. I authorize OHIOHEALTH GRANT MEDICAL CENTER, to verify any of the information I have provided, and further authorize any of the schools, institutions, or persons listed to provide any information about me contained in their records.

If I am accepted for any position by OhioHealth Grant Medical Center, I agree to abide by the policies, rules, regulations and practices of Grant Medical Center.

Signature	**Date**