

# FAMILY MEDICINE FACULTY DEVELOPMENT CENTER

## FELLOWSHIP APPLICATION

APPLICATION FOR FELLOWSHIP YEAR (Circle One):      08/09      09/10      10/11      11/12      12/13

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Address \_\_\_\_\_ Office Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Office Fax \_\_\_\_\_

If Non-U.S. Citizen, Date of Admission to U.S. \_\_\_\_\_ Type of Visa Held \_\_\_\_\_

### EDUCATION

Name and Address	Dates Attended		Major Field of Study	Degree
	From	To		
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### INTERNSHIP

Name and Address	Dates of Training		Type
	From	To	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### RESIDENCY

Name and Address	Dates of Training		Type
	From	To	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### OTHER POSTDOCTORAL TRAINING (Fellowships, etc.)

Position	Dept. or Field of Study	Name and Location of Institution	Dates of Training	
			From	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FELLOWSHIP APPLICATION - continued

LICENSURE (Give State and Year) \_\_\_\_\_

Certified by the American Board of \_\_\_\_\_ Date \_\_\_\_\_

Eligible for Certification by the American Board of \_\_\_\_\_

Membership in Honorary or Professional Societies, Fellowships, Award, etc.

If a graduate of a foreign medical school, have you obtained certification from the ECFMG? \_\_\_\_\_

If so, enclose photostatic copy of certificate. If not, please indicate your plans to obtain it.

**TEACHING EXPERIENCE**

Rank	Department	Institution	From	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**HOSPITAL APPOINTMENTS**

Rank	Department	Institution	From	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**CURRENT POSITION**

Rank	Department	Institution	From	To
_____	_____	_____	_____	_____

REFERENCES (List two persons - name and address - who you know well, from whom recommendations may be obtained.)

I certify that to the best of my knowledge the above information is accurate and that I have not knowingly withheld pertinent information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please send completed application to:

Faculty Development Center  
1600 Providence Drive  
Waco, Texas 76707  
(254) 752 - 2636  
Fax: (254) 756 - 0358  
<http://wacofdc.org>