STRONG MEMORIAL HOSPITAL
OF THE UNIVERSITY OF ROCHESTER
601 ELMWOOD AVENUE
ROCHESTER, NEW YORK 14642

PHOTO

A signed, recent photograph is not a requirement, but is very helpful

Application for Fellowships

NAME (Print) _____
First Middle Last

SOCIAL SECURITY NO. _____

PRESENT ADDRESS _____Phone_____
Street

_____
City State ZIP

PERMANENT ADDRESS _____Phone_____
Street

_____
City State ZIP

DATE OF BIRTH** _____ If not a U.S. Citizen: _____

PLACE OF BIRTH**_____ Type of Visa* _____

CITIZENSHIP** _____ Immigration No._____

Foreign Medical Graduates: ECFMG No._____
Standard or Interim?

Have you passed the Visa Qualitfying Examination?_____

NAME OF SPOUSE** _____

Or

NEAREST RELATIVE_____ Relation_____

ADDRESS OF RELATIVE _____ Phone_____

*Only J-1 visas are accepted for ACGME fellowships
**The New York State Human Rights prohibits discrimination because of race, creed, color, national origin, age, sex, disability or marital status.

Do you have any commitment for military or National Health Corps service? _____

EDUCATION: (Please indicate degrees to be granted and any non-degree work).

Degree (A.B., B.S., etc.)	University or College	Month	Year
Degree (M.D., D.D.S., etc.)	University or College	Month	Year
Other Degrees	University or College	Month	Year

How many honors did you receive in the 5 core clinical clerkships (Internal Medicine, General Surgery, Obstetrics/Gynecology, Pediatrics, and Psychiatry? _____

HOSPITAL AND CLINICAL EXPERIENCE, IF ANY

Position	Hospital	City	Dates
Position	Hospital	City	Dates

Have you ever been disciplined by, dismissed from, or not re-appointed to a previous residency or fellowship program? Yes _____ No _____ If so, provide details on separate sheet.

Can you come for a personal interview? _____

A personal interview is not a requirement, but is strongly recommended. Time of the Interview must be arranged in advance.

POSITION DESIRED _____

SERVICE _____**SERVICE TO BEGIN** _____

I certify that the information contained in 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. I further understand that upon appointment I will be required to document my citizenship and complete a health assessment which includes a physical examination and drug and alcohol testing.

Usual Signature (Written) _____
(Date)

1. Mail completed form to the subspecialty program contact person.
2. Letters of recommendation, proof of residency training, transcripts, USMLE scores, Dean's letter are required.
3. Foreign graduates: Should include copy of ECFMG certification.

THIS APPLICATION BECOMES – FOR THOSE APPOINTED – A PERMANENT RECORD.