

MAYFIELD CLINIC / UNIVERSITY OF CINCINNATI FELLOWSHIP APPLICATION

TYPE OF FELLOWSHIP

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebrovascular	Endovascular	Functional	Neurocritical Care	Pediatric	Skull Base	Spine	Surgical Neuro-oncology

Year Applying for: _____

PERSONAL INFORMATION

Name: _____
First
Middle
Last

Home Address: _____
Street
City
State
Zip Code
Country

Work Address: _____
Street
City
State
Zip Code
Country

Home Phone _____ Cell Phone _____ E-Mail Address _____

SS # _____ Date of Birth _____ Place of Birth _____

Country of Citizenship _____ Visa Status (if applicable) _____ ECFMG # _____ Valid Through _____

EDUCATION

Undergraduate: _____
Name of University
Dates of attendance
Degree earned

Graduate: _____
Name of University
Dates of attendance
Degree earned

Medical School: _____
Name of University
Dates of attendance
Degree earned

Residency: _____
Specialty
Program / University Name
Dates of attendance

USMLE Step 1 score _____ Pass Fail _____
USMLE Step 2 CS
USMLE Step 3 Score

Additional Documents Required
 Personal Statement, Current CV,
 3 Letters of Recommendation