MAYFIELD CLINIC / UNIVERSITY OF CINCINNATI
FELLOWSHIP APPLICATION

TYPE OF FELLOWSHIP

☐ 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

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