**Return Application and Supporting Documents to:**

**Neurological Institute Education Department**
**CLEVELAND CLINIC**
9500 Euclid Avenue, Cleveland, Ohio 44195
216-444-5539
Walshk3@ccf.org

(Please print or typewrite)

# Application for Clinical Post-Doctoral FELLOWSHIP

Application for Fellowship in _____

To begin _____Rotation Preferences_____ _____

Doctoral Program_____ PhD or PsyD _____Expected to Graduate _ _____ _____

Dissertation Topic _____ Defended_____

Pre-Doctoral Internship (APA Accredited) _____ _____

_____
Last Name First Middle (No Initial)

_____
Present Address Area Code / Telephone No. (Home-Work)

_____
City State Zip Code Country

_____
Permanent Address Area Code / Telephone No. (Home-Work)

_____
City State Zip Code Country

_____ _____ _ _____ _ _____
E-Mail Address U.S. Social Security Number

_____
Fax Number (If international, please provide country and city codes)

**EDUCATION:**

_____
College or University City/State Major

_____
Advanced Degree School City/State Dates from to Degree

_____
Graduate School City/State Dates from to Degree

**HOSPITAL EXPERIENCE:** (Please list all previous training. Use additional sheet if necessary)

_____
Intership–Hospital City/State from to no. mos. Specialty

_____
Internship–Hospital City/State from to no. mos. Specialty

_____
Internship–Hospital City/State from to no. mos. Specialty

**ADDITIONAL INFORMATION:**

1. Do you have a military or USPHS commitment? ❑ Yes ❑ No

   If yes: Starting_____for_____years in_____(Branch of service)

2. Citizen of U.S.? ❑ Yes ❑ No Permanent resident? ❑ Yes ❑ No A# _____

   If not, are you currently in the U.S.? If so, what is your status?

   ❑ Exchange Visitor Visa How long? ___

   ❑ Other ❑ Exp. date _____

   If not in the U.S., what type of Visa _____

The policy of The Cleveland Clinic Foundation is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment, transfers and promotions are all made upon the basis of the best qualified candidate without regard to color, race, religion, national origin, age, sex, handicapped status, ancestry or status as a disabled or Vietnam era veteran.

I certify that the information given or attached is true, accurate and complete.

Signed_____Date _____

Please provide all documents in one package.

Contact me if you have question

Check List

( ) – CV
( ) – Personal Statement
( ) – Clinic Sample
( ) – 3 Letters of Recommendation
( ) – Program Director Letter attesting status, date of dissertation defense and graduation date