

Return Application and Supporting Documents to:

**Neurological Institute Education Department
CLEVELAND CLINIC**

9500 Euclid Avenue, S100, Cleveland, Ohio 44195

216-903-9131

douglan3@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)

Internship-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