Cleveland Clinic

9500 Euclid Ave
Cleveland OH 44195

APPLICATION FOR HEADACHE MEDICINE FELLOWSHIP

Please print or type

Program Applied For: _____

To begin on _____ at Graduate Level _____

Last Name _____ First _____ Middle (No Initial) _____

Present Street Address _____ City _____ State _____ Zip Code _____ Country _____

Home Phone _____ Work Phone _____ Cell Phone _____

Permanent Address _____ Home Telephone _____ Work Telephone _____

City _____ State _____ Zip Code _____ Country _____

E-Mail Address _____ Fax Number (If international, please provide country and city codes) _____

EDUCATION:

College or University _____ City _____ State _____ Beginning _____ Ending _____ Major _____

Advanced Degree School _____ City _____ State _____ Beginning _____ Ending _____ Degree Granted _____

Medical School _____ City _____ State _____ Beginning _____ Ending _____ Degree Granted _____

CERTIFYING EXAMS:

☐ USMLE ☐ COMLEX ☐ Other: _____

Step or Part 1 _____ Step or Part 2 ck _____ Step or Part 2 cs _____ Step or Part 3 _____

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

Program _____ Hospital _____ City _____ State _____ beginning _____ - ending _____ ☐ U.S. ☐ International

Program _____ Hospital _____ City _____ State _____ beginning _____ - ending _____ ☐ U.S. ☐ International

Program _____ Hospital _____ City _____ State _____ beginning _____ - ending _____ ☐ U.S. ☐ International

Program _____ Hospital _____ City _____ State _____ beginning _____ - ending _____ ☐ U.S. ☐ International

Do you currently hold a medical license? ☐ Yes ☐ No

List states where you hold permanent licensure - include number and expiration date:

State	License Number	Expiration	State	License Number	Expiration

3. Have you ever been denied a medical license or had a license revoked? ☐ Yes ☐ No

If yes, explain: _____

_____

_____

_____

4. International Medical Graduates Only:

Are you certified by the E.C.F.M.G.? ☐Yes ☐No

Certificate number: _____ Certificate issue date: _____

5. Citizen of U.S.? ☐ Yes ☐ No If no, Permanent resident? ☐ Yes ☐ No If yes, Alien number: A# _____

If not a citizen or permanent resident, are you currently in the U.S.? ☐ Yes ☐ No

If so, what is your status?

☐ Exchange Visitor Visa (J-1) ☐ Research ☐ Clinical How long? _____

☐ H1B Visa ☐ Research ☐ Clinical How long? _____

☐ Other Exp. date _____

If not in the U.S., what type of Visa may we advise you about: ☐ J-1 ☐ H-1B

6. References and Supporting Documents:

PGYII/above: Please submit a CV, Personal Statement, Letter of support from your Residency Program Director in lieu of Dean's Letter, at least 2 letters of recommendation from other physicians who have supervised you in a clinical setting, USMLE (or COMLEX) score reports, and Medical School Diploma.

INTERNATIONAL GRADUATES:

In addition to the requirements above, please send a certified copy of your E.C.F.M.G. certificate.

REFERENCES AND SUPPORTING DOCUMENTS WILL NOT BE RETURNED.

The policy of the Cleveland Clinic and its system hospitals is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment, transfers and promotions are made upon the basis of the best qualified candidate without regard to color, race, religion, national origin, age, sex, sexual orientation, marital status, ancestry, status as a disabled or Vietnam era veteran or any other characteristic protected by law.

In signing this application I certify that the information given or attached is true, accurate, and complete.

Signed _____ Date _____