



*Department of Family and Community Medicine
Department of General Internal Medicine
Department of General Pediatrics*

**APPLICATION FOR
ACADEMIC FELLOWSHIP IN PRIMARY CARE RESEARCH**

Medical College of Wisconsin
Department of Family and Community Medicine
P.O. Box 26509
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Milwaukee, WI 53226-0509

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Fax: (414) 456-6523
Web Site: http://www.family.mcw.edu/f_academic.htm
E-mail: vruleford@mcw.edu

I. PERSONAL DATA

Name: _____
Last First MI

Social Security #: _____ - _____ - _____ Date of Birth: _____

Current Home Address: _____
Street Address Apartment #

City State Zip Code

Telephone: Home (_____) _____ - _____ Work / School (_____) _____ - _____ ext. _____

Fax: (_____) _____ - _____ E-mail Address: _____

Permanent Address: *(if different from above)*

Street Address Apt. #

City State Zip Code

Citizenship: _____ US _____ Other

*Visa Status: Type of Visa: _____

***Academic Fellowships are not accredited by ACGME.
They are not eligible for J-1 visa extension through ECFMG.**

II. EDUCATION

<i>Institution</i>	<i>Address</i>	<i>Dates Attended</i>	<i>Degree Received</i>
<i>Undergraduate School</i>		_____ to _____ <i>Mo./Yr. Mo./Yr.</i>	
<i>Graduate School</i>		_____ to _____ <i>Mo./Yr. Mo./Yr.</i>	
<i>Medical School</i>		_____ to _____ <i>Mo./Yr. Mo./Yr.</i>	
<i>Residency Program</i>		_____ to _____ <i>Mo./Yr. Mo./Yr.</i>	
<i>Residency Program</i>		_____ to _____ <i>Mo./Yr. Mo./Yr.</i>	

III. PROFESSIONAL EXPERIENCE

List your professional experience, beginning with the most recent.

Name of Organization/Company:

Dates:

_____ from _____ to _____
Mo./Yr. Mo./Yr.

Address:

Position held:

Duties:

Name of Organization/Company:

Dates:

_____ from _____ to _____
Mo./Yr. Mo./Yr.

Address:

Position held:

Duties:

IV. ACADEMIC INTEREST / RESEARCH EXPERIENCE

Please describe your areas of interest in research as well as any research experience you have. Attach additional sheet if necessary.

V. LETTERS OF RECOMMENDATION

List below three individuals who will write letters of recommendation for you. Please have these letters sent to our office within three (3) weeks of your application date. Include the director of your residency program.

A. Name _____

Institution _____

Address _____

Telephone Number (_____) _____ - _____ **ext.** _____

B. Name _____

Institution _____

Address _____

Telephone Number (_____) _____ - _____ **ext.** _____

C. Name _____

Institution _____

Address _____

Telephone Number (_____) _____ - _____ **ext.** _____

VI. LICENSURE / BOARD CERTIFICATION

Medical Licenses: State _____ Number _____ Date Issued _____ Exp. Date _____

Medical Licenses: State _____ Number _____ Date Issued _____ Exp. Date _____

In which practice specialties are you board eligible / board certified?

_____ Year of eligibility _____ Certification _____
_____ Year of eligibility _____ Certification _____

US DEA Certification number _____

Indicate the year you successfully completed certification exam(s):
USMLE Step I _____ Step II _____ Step III _____
FLEX Component I _____ Component II _____

Yes **No**

- A. Have you ever been convicted for an offense other than a minor traffic violation or have pending criminal charges against you? (No applicant will be denied a position because of a conviction for an offense or because of a pending criminal charge which is not substantially related to the circumstances of the position sought.) _____
- B. Do you have any disciplinary actions initiated or currently pending against your medical license(s) in any state? _____
- C. Has there been any actions taken against any privileges you currently hold or have previously held? _____
- D. Has your medical license or DEA certificate been revoked, suspended, denied, restricted, limited or issued/placed in a probational status or voluntarily relinquished? _____

If you answered "yes" to any of the above, explain. Attach additional sheets as necessary.

VII. APPLICANT'S CERTIFICATION

I hereby state that all information provided on this application form is accurate.

Applicant's signature

Date