**SAINT LOUIS UNIVERSITY HEALTH SCIENCES CENTER**

**APPLICATION FOR POSTGRADUATE**

 **TRAINING IN THE DEPARTMENT**

 **OF**

 **CLINICAL NEUROPHYSIOLOGY FELLOWSHIP**

 **Attach photo here**

 **LEVEL FOR WHICH YOU ARE APPLYING: PGY V**

 **1. NAME:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **LAST FIRST MIDDLE**

 **2. ADDRESS:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **PRESENT (not the medical school's address)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **PERMANENT ADDRESS (if different from above)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **TELEPHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAY-TIME TELEPHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLACE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SOCIAL SECURITY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITIZENSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. APPLICANT MUST PROVIDE:**

 **A. Complete transcript of medical school record & diploma.**

 **B. Three letters of recommendation from a representative or director of your**

 **postgraduate training program.**

 **4. PREVIOUS EDUCATION AND TRAINING:**

 **NAME & LOCATION FROM TO MAJOR & DEGREE**

 **COLLEGES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MEDICAL SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **INTERNSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NAME & LOCATION FROM TO SPECIALTY**

 **RESIDENCIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **FELLOWSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. PREVIOUS SUPERVISORS AND DIRECTORS OF GRADUATE MEDICAL TRAINING**

 **(If currently in medical school, please give the name of the dean):**

 **DIRECTORS'NAMES AND MAILING ADDRESSES**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6. HONORS: Does your school have an AOA Chapter? \_\_\_Yes \_\_\_ No**

 **If so, are you a member? \_\_\_Yes \_\_\_ No**

 **Note: If you are elected after sending this application, please let us know.**

 **NATIONAL BOARD SCORES: PART I PART II PART III**

 **Overall score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **UNITED STATES MEDICAL**

 **LICENSING EXAM (USMLE): STEP I STEP II STEP III**

 **Overall Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **FEDERATION LICENSING**

 **EXAMINATION (FLEX): COMP I COMP II**

 **Overall score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **State/Date taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. L I C E N S U R E (If you are currently enrolled in medical school, skip #7 and #8):**

 **Do you have a permanent or temporary license to practice medicine in the State of Missouri? \_\_\_Yes \_\_\_ No**

 **List any and all licensures (temporary and/or permanent) you have held in other jurisdictions:**

 **STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE ISSUED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE ISSUED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE ISSUED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE ISSUED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **DRUG NUMBER: DEA (BNDD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE ISSUED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Has your licensure to practice medicine in any jurisdiction ever been**

 **suspended, revoked, or placed under investigation? \_\_\_Yes \_\_\_ No**

 **Has your license or registration to prescribe narcotics ever been**

 **suspended, revoked, or placed under investigation? \_\_\_Yes \_\_\_ No**

 **Have you ever been named or otherwise involved in any**

 **malpractice claim or settlement? \_\_\_Yes \_\_\_ No**

 **Have you ever been convicted of a felony, pleaded "NOLO CONTENDRE,"**

 **or have you ever been placed on probation for any offense other than a**

 **traffic violation? \_\_\_Yes \_\_\_ No**

 **If you answered "Yes" to any of the above, please provide the details**

 **on a separate sheet of paper.**

 **Have you ever been licensed to practice medicine under a different name?**

 **\_\_\_Yes \_\_\_ No If yes, please indicate name:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8. Please identify any medical practice or employment as a physician since graduation from medical school other than postgraduate training listed on pages one and two. Please indicate dates.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**9. INTERNATIONAL MEDICAL GRADUATES:**

 **Do you have a valid visa? \_\_\_Yes \_\_\_ No**

 **If yes: Type\_\_\_\_\_\_ Number \_\_\_\_\_\_ Date Issued \_\_\_\_\_\_\_\_**

 **Do you have a permanent ECFMG Certificate? \_\_\_Yes \_\_\_ No**

 **If yes, please provide a copy of the certificate.**

 **Certificate Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date Issued\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Have you passed the ECFMG / VQE / FLEX / TOEFL Examination?**

 **\_\_\_Yes \_\_\_ No**

 **If yes, indicate exam and score(s):**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Are you scheduled to take any of the above-listed tests?**

 **\_\_\_Yes \_\_\_ No**

 **If yes, indicate type and scheduled date:**

 **Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**10. Please attach a one page personal statement describing your career goals and aspects of your background and medical school experiences which have led to your interest in this specialty. Your application will not be considered complete without this.**

**11. Please attach a complete curriculum vitae and bibliography.**

**In making application for appointment to the housestaff of Saint Louis University Hospital (Saint Louis University School of Medicine), I certify that the information contained on this application is true and correct. I fully understand that any significant misstatements in or omissions from this application constitute cause for summary dismissal.**

**Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**