

**GRADUATE MEDICAL EDUCATION
RESIDENCY AND FELLOWSHIP
APPLICATION**

UNIVERSITY OF ILLINOIS AT CHICAGO AND AFFILIATED GRADUATE MEDICAL EDUCATION PROGRAMS APPLICATION REQUIREMENTS

Please read the following and the attached application form carefully and provide the information and credentials requested. Only complete application files can be processed for appropriate review and subsequent recommendations.

1. All first year post medical school appointments (no prior approved graduate training) are made via the National Resident Matching Program (2450 North State NW, Suite 201, Washington, DC 20037-1141). NRMP applications but please note the additional requirements from the list below.
2. The following credentials are to be forwarded to this office as promptly as possible:
 - a. Copy of transcripts of medical or osteopathy school records (Originals will be required at the time of interview). A copy of M.D./D.O. diploma.
 - b. Foreign school graduates: copies of ECFMG certificate, medical school diploma, and license to practice medicine in home country with translations of documents if they are not in English. Transcripts of medical school must be notarized if not original.
 - c. Four letters of recommendation addressed to the Program Director of the Fellowship Program and should include one from the Dean of your School and three from faculty or staff who are familiar with your performance record. If the latter are acquainted with the Program Director, they may prefer to write directly to him/her.
 - d. Important-Physician Candidates-We require reference letters from Program Directors of all accredited U.S. residencies of fellowships in which you have served and if applicable from current.
 - e. Copies of USMLE scores, NBME scores, ECFMG scores, FMGEMS scores, FLEX scores.
 - f. Curriculum Vitae
 - g. Personal Statement: This should include you professional interests, achievements, and plans for the future. Reference should be made to research experience and training, special projects or scientific work you have engaged in, and any notable professional accomplishments you have achieved. You may also wish to describe your personal interests, activities, and circumstances including your family and household.
3. Personal interviews are very helpful, and in most programs are essential. These are to be arranged directly with the office of the Director of the program for which you are applying. Do not call the Graduate Medical Education Office.

Please return all forms and credentials to:

University of Illinois at Chicago
Attention: Maria Mata/Fellowship Program
Dept. of Neurology and Rehabilitation (M/C 796)
912 S. Wood Street, Ste. 855N
Chicago, Illinois 60612

The University of Illinois policy is to be in full compliance with all federal and state nondiscrimination and equal opportunity laws, orders and regulations, and it will not discriminate against any persons because of race, color, sex, religion, handicap, or national origin in any of its educational programs and activities.

I hereby apply for clinical graduate training in

_____ (specialty program)

at _____ year level, to begin

I am participating in NRMP Yes No

I am participating in another matching program _____

PLEASE INCLUDE A
PHOTOGRAPH

Please Print

Name: _____
(LAST) (FIRST) (MIDDLE)

Soc. Sec. # _____

Date of Birth _____

Email Address: _____

Mailing Address: _____

_____ Phone _____
City or Town State or Country Zip Code

Permanent Home Address _____

(If different from above)

_____ Phone _____
City or Town State or Country Zip Code

USA Citizen _____ Foreign Citizen _____
(city/state of birth) (country)

Permanent Immigration Visa # _____ J Visa

Do you have any condition that would preclude you from forming rational judgments, reacting quickly in emergent situations, or working for an extended period of time (i.e. night call) under stressful conditions without interruption? If yes, attach a detailed explanation. Yes No

Have you ever been convicted of any criminal offense in any state or in federal court (other than minor traffic violations) If yes, attach statement including date and place of conviction(s) and nature of such offense. Yes No

RECORD OF LICENSURE

A license to practice in Illinois, either temporary or permanent, is mandatory.

Are you licensed to practice medicine in Illinois? If yes, submit a copy of license Yes No

Date of certificate _____ Expiration date _____ License # _____

I have been license to practice medicine in the following states:

	State	License#	Date of Issue	Expiration Date
Original License	_____	_____	_____	_____
Other License	_____	_____	_____	_____
Other License	_____	_____	_____	_____
Other License	_____	_____	_____	_____

Have you ever been denied a license or permit, or privilege of taking an examination by any Yes No

Have you ever had a license or permit encumbered in any way (revoked, suspended, surrendered, censored, restricted, limited, placed on probation) If yes, attach a detailed explanation Yes No

Have you ever been named in a malpractice suit? If yes, attach detailed explanation Yes No

EDUCATION (a) College or University (include graduate work)	DEGREE and field	DATES ATTENDED	
(b) Medical, Dental, or Osteopathy School			

PREREQUISITES: I have passed the following examinations: (give date and score)

	Date Month/Year	Score	Place	Date Month/Year	Score
USMLE/NBME Pt. I			State Lic. Exam		
USMLE/NBME Pt. II			Flex		
USMLE/NBME Pt. III			VQE		
ECFMG			FMGEMS		

My ECFMG # is _____

INTERNSHIP: Flexible _____ Straight _____
(Specialty)

at _____ in _____
(Location)

RESIDENCY or FELLOWSHIP in _____
(Specialty)

at _____ in _____
(Institution) (Location)

at _____ in _____
(Institution) (Location)

at _____ in _____
(Institution) (Location)

RESEARCH TEACHING EXPERIENCE:
_____ in _____
(Rank) (Field)

at _____ In _____
(Institution) (Location)

DATES SERVED	

under the direction of _____

Other medical Experience: _____

Scholarships, prizes, or awards: _____

Membership in professional and/or honorary societies _____

Publications (Please submit a list, or copy of each, if available)

REFERENCES: List below the names and positions of those you have requested to write on your behalf. We require original letters. We do not accept Xerox copies.

Medical Students: We require Dean's letter as well as letters from three faculty or staff who are familiar with your performance record.

Physician Candidates: In addition to the Dean's letter or equivalent, we require letters from all program directors or any accredited U.S. residencies or fellowships in which you have served and from current or past medical employers.

Name _____ Position _____

Name _____ Position _____

Name _____ Position _____

Name _____ Position _____

Check one: I hereby waive access to the above letters and will so inform the authors

I desire access to the above letters and will so inform the authors

I HAVE READ AND UNDERSTAND THE INSTRUCTIONS FOR THE COMPLETION OF THIS APPLICATION. I CERTIFY THAT THE INFORMATION SUBMITTED ON THIS APPLICATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THIS POSITION OR BE GROUNDS FOR TERMINATION IN CASE OF EMPLOYMENT.

SIGNATURE OF APPLICANT _____ Date _____