Print Form

COMMON APPLICATION FOR OHIO STATE UNIVERSITY
DIVISION OF CARDIOVASCULAR MEDICINE FELLOWSHIP TRAINING

Program: _____

Month/Year to begin program: _____

Insert Recent Photo of Applicant Here

Attach image file

PROFILE

Last Name | First Name | Middle Initial | Suffix

Previous Last Name | Preferred Name | Gender

Birth Place | Birth Date

Social Security Number | Contact Email

PRESENT MAILING ADDRESS/CONTACT INFORMATION

Country | Street Address

City | State/Province | Zip Code

Preferred Phone | Alternate Phone

Pager | Mobile | Fax

EDUCATION (include only higher education)

For each non-medical educational institution you have attended, please provide the requested information.

Entry 1

Institution

Education Type
◯ Undergraduate ◯ Graduate ◯ Other

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

Entry 2

Education Type
◯ Undergraduate ◯ Graduate ◯ Other

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

Entry 3

Institution

Education Type
◯ Undergraduate ◯ Graduate ◯ Other

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

Entry 4

Institution

Education Type
◯ Undergraduate ◯ Graduate ◯ Other

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

MEDICAL EDUCATION

For each medical school you have attended, please provide the requested information.

Entry 1

Institution | Country

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

Entry 2

Institution | Country

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

Entry 3

Institution | Country

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

Entry 4

Institution | Country

City | State | Degree

Dates of Attendance - From Month/Year To Month/Year

Was your medical education training ever extended or interrupted?

◯ Yes ◯ No

Reason

GRADUATE MEDICAL EDUCATION TRAINING

For each residency, fellowship or osteopathic training position you have held or currently are in, regardless of the amount of time spent there, please provide the requested information.

PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE

Was your training ever extended or interrupted?

◯ Yes ◯ No

Reason

EXPERIENCE(S)

Provide the requested information for each relevant work, research, and volunteer experience/position. Include clinical and teaching experience as work experiences, and include all unpaid extracurricular activities and committees you have served on as volunteer experiences.

Entry 1

Organization

Experience Type

◯ Work ◯ Research ◯ Volunteer

Position

Dates of Experience - From Month/Year To Month/Year

City

State/Province

Country

Description:

Entry 2

Organization

Experience Type

◯ Work ◯ Research ◯ Volunteer

Position

Dates of Experience - From Month/Year To Month/Year

City

State/Province

Country

Description:

Entry 3

Organization

Experience Type

◯ Work ◯ Research ◯ Volunteer

Position

Dates of Experience - From Month/Year To Month/Year

City

State/Province

Country

Description:

Entry 4

Organization

Experience Type

◯ Work ◯ Research ◯ Volunteer

Position

Dates of Experience - From Month/Year To Month/Year

City

State/Province

Country

Description:

EXAMINATIONS

For each examination you have taken, please provide the requested information. (Osteopathic applicants: include the exams (COMLEX or USMLE) that lead to the medical licensure route you intend to pursue.)

EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.	Month/Year	Status	Score(s)
		◯ Passed ◯ Awaiting results ◯ Failed ◯ Will take	
EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.	Month/Year	Status	Score(s)
		◯ Passed ◯ Awaiting results ◯ Failed ◯ Will take	
EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.	Month/Year	Status	Score(s)
		◯ Passed ◯ Awaiting results ◯ Failed ◯ Will take	
EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.	Month/Year	Status	Score(s)
		◯ Passed ◯ Awaiting results ◯ Failed ◯ Will take	

STATE MEDICAL LICENSE(S)

For each state license you have, please provide the requested information.

State	License Type	License Number	Expiration Month/Year
	◯ Full ◯ Temporary or Limited ◯ Inactive		
State	License Type	License Number	Expiration Month/Year
	◯ Full ◯ Temporary or Limited ◯ Inactive		
State	License Type	License Number	Expiration Month/Year
	◯ Full ◯ Temporary or Limited ◯ Inactive		

Has your medical license ever been suspended/revoked/voluntarily terminated?

◯ Yes ◯ No

Reason

Have you ever been named in a malpractice case?

◯ Yes ◯ No

Reason

Is there anything in your past history that would limit your ability to be licensed or receive hospital privileges?

◯ Yes ◯ No

Reason

Have you ever been convicted of a felony?

◯ Yes ◯ No

Reason

PUBLICATIONS

List publications of the following types:

- ◯ Peer Reviewed Journal Articles/Abstracts
- ◯ Peer Reviewed Journal
- ◯ Articles/Abstracts -Submitted, Provisionally Accepted, Accepted or In-Press
- ◯ Peer Reviewed Book Chapter
- ◯ Scientific Monograph
- ◯ Other Articles
- ◯ Peer Reviewed Online Publication
- ◯ Non Peer Reviewed Online Publication

PRESENTATIONS

List publications of the following types:

- ◯ Poster Presentation
- ◯ Oral Presentation

AWARDS/ACCOMPLISHMENTS

MEMBERSHIPS IN HONORARY/PROFESSIONAL SOCIETIES

CITIZENSHIP AND VISA STATUS

What is your citizenship status?

- ◯ U.S Citizen
- ◯ Foreign National
- ◯ Permanent Resident
- ◯ Conditional Permanent Resident

Current Visa Type (for Foreign Nationals only)

- ◯ F-1 Academic student
- ◯ H-1B Specialty occupation
- ◯ H-4 Spouse or child of H-1, H-2, H-3
- ◯ J-1 Visa for exchange visitor
- ◯ J-2 Spouse or child of J-1
- ◯ EAD - Employment Authorization
- ◯ Immigrant
- ◯ Other

INTERNATIONAL MEDICAL GRADUATES

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

- ◯ Yes
- ◯ No
- ◯ Not applicable

Month/Year of certification: _____

To be answered by International Medical Graduates (IMG's) only: Is there anything in your past history that would limit your ability to be licensed or receive hospital privileges?

- ◯ Yes
- ◯ No

Describe limitation

MISCELLANEOUS

Are you Board Certified?

- ◯ Yes
- ◯ No

Board Name

Are you a member of Alpha Omega Alpha?

- ◯ Yes
- ◯ No
- ◯ Not applicable (osteopathic applicant or no AOA chapter at my school)

Are you a member of Sigma Sigma Phi?

- ◯ Yes
- ◯ No
- ◯ Not applicable (allopathic applicant or no SSP chapter at my school)

Are you ACLS (Advanced Cardiac Life Support) certified in the USA?

- ◯ Yes
- ◯ No

ACLS certification expiration date: _____

Do you have a DEA number?

- ◯ Yes
- ◯ No

DEA Registration Number: _____

Expiration date: _____

Language fluency, other than English:

Hobbies and Interests:

Race (Optional): You may select one or more races. You are not required to identify your race. If you choose not to identify your race, please select "No Answer."

- ◯ No Answer
- ◯ White
- ◯ Black
- ◯ American Indian or Alaskan Native
  Please specify the name of enrolled or principle tribe:
- ◯ Asian
  - ◯ Asian Indian
  - ◯ Pakistani
  - ◯ Filipino
  - ◯ Japanese
  - ◯ Korean
  - ◯ Vietnamese
- ◯ Other

Ethnicity (Optional): You are not required to identify your ethnicity. If you choose not to identify your ethnicity, please select "No Answer." You may indicate whether you're Spanish/Hispanic/Latino/Latina or not.

- ◯ No Answer
- ◯ Not Spanish/Hispanic/Latino/Latina
- ◯ Spanish/Hispanic/Latino/Latina
  Please specify the name of enrolled or principle tribe:
  - ◯ Mexican
  - ◯ Mexican American
  - ◯ Chicano/Cicana
  - Puerto Rican
  - Cuban
  - Other

PERSONAL STATEMENT

Do not exceed 750 words

CERTIFICATION

I certify that the information contained within my application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; or if employed, may constitute cause for termination from the program

- ◯ Yes
- ◯ No

Signature _____ Date _____

Please print and mail this to OSU Cardiovascular Medicine Fellowship Program, 473 W. 12th Ave - 200 HLRI, Columbus, OH 43210. Application will be reviewed when all supporting documents as noted on website are received.