Division of Cardiovascular Medicine
Oregon Health & Science University
Application forClinical Cardiac Electrophysiology Fellowship Program
(For Academic Year Beginning _____________)

Name: First:		Middle Initial:	Last:	
Previous last name, if any:				
Email:				
Gender:				
Birth date:				
Birth place (City/State/Country):				
SSN:				
Citizenship:				
Visa Type (if applicable):				
ECFMG Certification:	Certification Date (mm/yyyy):		Expiration date: (mm/yyyy):	
Race:				
Ethnicity:				
Contact Address:		Permanent Mailing Address:		
Preferred Phone #:				
Alternate Phone #:				
Mobile #:				
Pager #:				
Fax #:				

Medical School:			
Institution & Location:	Dates Attended:	Degree:	Graduation Date (mm/yyyy):

Graduate School:				
Institution & Location:	Field of Study:	Degree:	From (mm/yyyy):	To (mm/yyyy):

Internal Medicine Residency:			
Institution & Location:	Program Director	From (mm/yyyy):	To (mm/yyyy):

Cardiovascular Fellowship:			
Institution & Location:	Program Director	From (mm/yyyy):	To (mm/yyyy):

Other Fellowships:?			
Institution & Location:	Program Director	From (mm/yyyy):	To (mm/yyyy):

Professional Experience:					
Experience:	Organization:	Position:	Dates:	Avg Hrs/Wk:	Supervisor:

Research:					
Experience:	Organization:	Position:	Dates:	Avg Hrs/Wk:	Supervisor:
	Description:				
Experience:	Organization:	Position:	Dates:	Avg Hrs/Wk:	Supervisor:
	Description:				
Experience:	Organization:	Position:	Dates:	Avg Hrs/Wk:	Supervisor:
	Description:				

Military Obligation/ Deferment?		Years:		Branch:
Other service oblication?	Yes ____________	No ____________	Description:	
Felony Conviction?	Yes ____________	No ____________	Reason:	
Limitations?	Yes ____________	No ____________	Description:	

Examinations			
Examination:	Date taken (mm/yyyy)	Scores	Status (pass/fail)
USMLE Step 1			
(Clinical Knowledge)			
Skills)			
USMLE Step 2			
(Clinical Knowledge)			
Skills)			
Usmle Step 3			

State Medical Licenses				
Type (Temorary/limited, Full/Unlimited)	License Number	State	Effective Date (mm/yyyy)	Expiration Date (mm/yyyy)

ACLS:	Yes _____ No_____	Effective Date: (mm/yyyy)		Expiration Date: (mm/yyyy)	
PALS:	Yes _____ No_____	Effective Date: (mm/yyyy)		Expiration Date: (mm/yyyy)	
DEA Reg. #:		Effective Date: (mm/yyyy)		Expiration Date: (mm/yyyy)	
NPI #:		Effective Date: (mm/yyyy)		Expiration Date: (mm/yyyy)	
Board Certification:	Yes _____ No_____	Effective Date: (mm/yyyy)		Expiration Date: (mm/yyyy)	
Medical Licensure Problem?	Yes _____ No_____	Reason:			
Ever named in a malpractice suit?	Yes _____ No_____	Reason:			

Membership in Honorary/Professional Societies:

Publications: (You may attach as a separate document or "refer to CV")

Hobbies/Interests:

Language Fluency (other than English):

Other Awards/Accomplishments:

Certification:	I certify that the information contained in this 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 fellowship position, or if employed, may constitute cause for termination from the fellowship program.	
Certified by:		Date: