Division of Cardiovascular Medicine

Oregon Health & Science University

Application for Heart Failure Fellowship Program

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/Unrestricted)	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: