



Grant Medical Center
 Department of Medical Education
 111. South Grant Avenue
 Columbus, OH 43215
 Phone: (614) 566-9290
 Fax: (614) 566-8073

PHOTO: Optional

Date of Application: _____

EQUAL OPPORTUNITY EMPLOYER				PLEASE PRINT OR TYPE IN BLACK INK			
I wish to apply for: Fellowship							
<input type="checkbox"/> Breast Surgery		<input type="checkbox"/> Colon and Rectal Surgery					
<input type="checkbox"/> Hospital Medicine		<input type="checkbox"/> Orthopaedic Trauma					
<input type="checkbox"/> Surgical Critical Care							
<input type="checkbox"/> Ophthalmic Trauma & Emergency							
For the following time period: (MM/DD/YY) _____ to (MM/DD/YY) _____							
APPLICANT INFORMATION							
Last	First	Middle	NPI Number				
Mailing Address			City	State	Zip		
Home/Cell Phone #		Work Phone #		E-Mail			
Other Address			City	State	Zip		
Birthplace: City		State	Country		Citizenship		
REFERENCES							
References should include name, title, complete address and phone number. Please provide a reference letter from your current Residency Program Director, in addition to three other reference letters.							
Name		Title		Address		Phone	
Name		Title		Address		Phone	
Name		Title		Address		Phone	
Program Director:				Address		Phone	

EDUCATION

Undergraduate School	Degree	Address	Phone
Medical School	Degree	Address	Phone

Medical School Graduation Date

Month Date Year

RESIDENCY

PGY 1 Hospital	Address	Phone	Start Date	End Date
PGY 2 Hospital	Address	Phone	Start Date	End Date
PGY 3 Hospital	Address	Phone	Start Date	End Date
PGY 4 Hospital	Address	Phone	Start Date	End Date
PGY 5 Hospital	Address	Phone	Start Date	End Date
Other Hospital	Address	Phone	Start Date	End Date

MEDICAL LICENSURE

Current Licenses	State	Number	Exp Date	State	Number	Exp Date
DEA						

Have you completed the DATA Waiver training to obtain your X-DEA certification? ___ Yes ___ No

EXAMINATION

COMLEX 1 Score	Date	COMLEX 2 Score	Date	COMLEX 3 Score	Date
USMLE 1 Score	Date	USMLE 2 Score	Date	USMLE 3 Score	Date
NBME 1 Score	Date	NBME 2 Score	Date	NBME 3 Score	Date
Other	Date	Other	Date	Other	Date

INTERNATIONAL GRADUATES			
OhioHealth Grant Medical Center will consider applicants who are U.S. citizens, lawful permanent residents, asylees and refugees, and other individuals with work authorizations that do not require visa sponsorship by Grant Medical Center.			
ECFMG Certificate Number	FMGEMS Score	Date Issued	Expiration Date
Green Card #		Issue Date	
<p>Have you ever been convicted of:</p> <p>1. Misdemeanor Conviction in the United States? ___No ___Yes.</p> <p>2. Felony Conviction of a felony, sex crime, or misappropriation of funds in the United States? ___No ___Yes</p> <p>3. Limitations? ___No ___Yes.</p>			
PLEASE INCLUDE YOUR PERSONAL STATEMENT AND CURRICULUM VITAE			
<p>Authorization and Release:</p> <p>To the best of my knowledge, the information that I have provided in this application is true and free of any consequential omissions. I authorize OHIOHEALTH GRANT MEDICAL CENTER, to verify any of the information I have provided, and further authorize any of the schools, institutions, or persons listed to provide any information about me contained in their records.</p> <p>If I am accepted for any position by OhioHealth Grant Medical Center, I agree to abide by the policies, rules, regulations and practices of Grant Medical Center.</p>			
Signature			Date