CENTER FOR EARS, NOSE, THROAT & ALLERGY, P.C.
12188 N. Meridian St., Suite 375
Carmel, Indiana 46032
(317) 926-1056 Fax (317) 579-0476

APPLICATION FOR FELLOWSHIP

Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	
Street Address		
City	State	Zip Code
Home Telephone	Alternate Telephone/Pager	
Fax	E-mail	
Country of Residence	Citizenship	Visa Type & Exp. Date
ECFMG Number (applicable to foreign medical graduates)		Date Issued
Applying for Fellowship beginning in:	Month:	Year:
What is your present position?		
EDUCATION & TRAINING		
Undergraduate School (name and location)	Dates Attended	Degree/Date awarded
Undergraduate School (name and location)	Dates Attended	Degree/Date awarded
Graduate School (name and location)	Dates Attended	Degree/Date awarded
Medical School (name and location)	Dates Attended	Degree/Date awarded
Internship: Institution name and location	Type	Dates
Program Chairman		Phone
Residency: Institution name and location	Specialty	Dates
Program Chairman		Phone
Did you successfully complete the program? Yes / No (If "No," please explain on separate sheet)		
Residency: Institution name and location	Specialty	Dates
Program Chairman		Phone
Did you successfully complete the program? Yes / No (If "No," please explain on separate sheet)		
Fellowship: Institution name and location	Specialty	Dates
Program Chairman		Phone
Did you successfully complete the program? Yes / No (If "No," please explain on separate sheet)		
BOARD CERTIFICATION Specialty:		Date

PROFESSIONAL LICENSURE		
State:	License Number	Expiration Date
State:	License Number	Expiration Date

WORK HISTORY: Please describe any work hIstory since the completion of postgraduate training, including military assignments.

PRESENTATIONS TO SCIENTIFIC MEETINGS: Please attach list, including topic and/or title of paper, co-authors, meeting at which presented, and dates

PUBLICATIONS: Please attach list of all publications of which you were principal or co-author.

PROFESSIONAL REFERENCES: Please have letters of reference sent directly to us from three (3) physicians who have been in a position to evaluate your knowledge, skills, and work habits. So that we may follow up with them if we do not receive their letters, provide the following information:

Name	Title/Position
Address	Phone:
	Fax:
Name	Title/Position
Address	Phone:
	Fax:
Name	Title/Position
Address	Phone:
	Fax:

ATTACH:

1. Curriculum vitae
2. Recent photograph
3. List of presentations, if any
4. List of publications, if any
5. Cover letter with any additional comments

I certify that that all of the information I have provided and the responses I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination. My signature here authorizes verification of the information I have provided and authorizes listed references to provide full and complete responses of any pertinent information they may have.

Full legal signature	Date