



**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?		
<b>EDUCATION &amp; TRAINING</b>		
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

<b>PROFESSIONAL LICENSURE</b>		
State:	License Number	Expiration Date
State:	License Number	Expiration Date
<b>WORK HISTORY:</b> Please describe any work history since the completion of postgraduate training, including military assignments.		
<b>PRESENTATIONS TO SCIENTIFIC MEETINGS:</b> Please attach list, including topic and/or title of paper, co-authors, meeting at which presented, and dates		
<b>PUBLICATIONS:</b> Please attach list of all publications of which you were principal or co-author.		
<b>PROFESSIONAL REFERENCES:</b> 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:	
<b>ATTACH:</b>		
<ol style="list-style-type: none"> <li>1. Curriculum vitae</li> <li>2. Recent photograph</li> <li>3. List of presentations, if any</li> <li>4. List of publications, if any</li> <li>5. Cover letter with any additional comments</li> </ol>		
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	