

**St. John Hospital and Medical Center**  
**Department of Medical Education**  
**Infectious Diseases Fellowship Application**  
**For Graduates of International Medical Schools**

NRMP Participant:  Yes  No NRMP # \_\_\_\_\_ Start Date \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I.

Residencies (if applicable): If more than one residency, please attach dates, etc. on a separate sheet.  
Please enclose copy of residency certificate.

Hospital: \_\_\_\_\_ Type of Residency: \_\_\_\_\_

Address: \_\_\_\_\_

Dates: \_\_\_\_\_ Program Director (if known): \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Previous Fellowships (if applicable): If more than one fellowship, please attach dates, etc. on a separate sheet. Please enclose copy of residency certificate.

Hospital: \_\_\_\_\_ Type of Fellowship: \_\_\_\_\_

Address: \_\_\_\_\_

Dates: \_\_\_\_\_ Program Director: \_\_\_\_\_

**Educational Data:**

Medical School: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_  
(Enclose photocopy of Diploma if applicable)

Premedical School: \_\_\_\_\_ Degree: \_\_\_\_\_

**Visa Information:**

U.S. Citizen?  Yes  No If no, what type of visa do you hold? (Enclose copy, if available)

\_\_\_\_\_

Visa Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**Test Data:**

Score for Part/Step I (Basic): \_\_\_\_\_ USMLE (2 Digit) \_\_\_\_\_ USMLE (3 Digit) \_\_\_\_\_ NBOME \_\_\_\_\_

Score for Part/Step II (Clinical): \_\_\_\_\_

Score for Part/Step III (If applicable): \_\_\_\_\_

**ECFMG Information:**

ECFMG Valid Until: \_\_\_\_\_ ECFMG Number: \_\_\_\_\_

If you do not currently have a valid ECFMG certificate, explain why: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**License Information (if applicable):**

Licensed in state(s) of U.S.: \_\_\_\_\_

Temporary #: \_\_\_\_\_ Permanent #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Present Address: \_\_\_\_\_  
Street City  
\_\_\_\_\_  
State Zip Phone (day) (eve) (pg)

Address you would like  
mail sent to (if not above): \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip Phone

Do you prefer receiveing your information via E-mail or regular mail: \_\_\_\_\_

Please include a C.V. and list all academic honors, scientific papers, and any additional experience (other than the residencies listed above) on a separate sheet(s) of paper and attach to this application:

Please forward a letter of recommendation from your Chief or Program Director (mandatory), as well as your Dean's letter and name two medical or health care professionals who have personal knowledge of your current clinical abilities, ethical character and ability to work cooperatively with others and who will provide specific written comments on these matters. The named individuals must have acquired the requisite knowledge through recent observation of your performance over a reasonable period of time. One of these references must have had organizational responsibility for your performance: i.e., department chairman, service chief or clinical faculty member. PLEASE FORWARD THESE DOCUMENTS TO: DEPARTMENT OF MEDICAL EDUCATION, ST. JOHN HOSPITAL AND MEDICAL CENTER, 22101 MOROSS ROAD, DETROIT, MI 48236

Reference Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City  
\_\_\_\_\_  
State Zip Phone E-mail (if known)

Reference Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City  
\_\_\_\_\_  
State Zip Phone E-mail (if known)

I certify that the above information and any other information furnished by me during the application process is true and accurate. I understand that having supplied inaccurate, false or misleading information may be grounds for rejection of my application or for immediate dismissal from the fellowship program, if I am accepted. Furthermore, I fully and completely understand that I will be subject to all other applicable hospital policies and procedures and that violation of any of these may result in release from the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Applicant)