

**St. John Hospital and Medical Center
Department of Medical Education
Infectious Diseases Fellowship Application
For Graduates of U.S. 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: _____

| Test Data: | USMLE (2 Digit) | USMLE (3 Digit) | NBOME |
|------------|-----------------|-----------------|-------|
|------------|-----------------|-----------------|-------|

Score for Part/Step I (Basic): _____

Score for Part/Step II (Clinical): _____

Score for Part/Step III (If applicable): _____

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 receiving your information via E-mail or regular mail: _____

Citizenship (Complete only if you are not a U.S. citizen):

What type of visa do you hold? (Enclose copy, if available): _____

Number: _____ Expiration Date: _____

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)