UNIVERSITY OF ALABAMA AT BIRMINGHAM

DEPARTMENT OF MEDICINE
DIVISION OF NEPHROLOGY

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APPLICATION FOR TRANSPLANT FELLOWSHIP PROGRAM

YEAR APPLYING FOR _____ Date of Application _____

Name (Last, First, Middle, no initials)_____

Maiden Name (if applicable) _____

Social Security Number _____

Office Address_____

Fax #_____ Telephone_____ E-mail Address: _____

Home Address_____

E-mail Address:_____Telephone_____

Citizen of_____ (if not U.S. Citizen complete Page 3, Non-US Citizens And Graduates section)

Sociodemographic Data:

Place of Birth _____ Date of Birth_____
City/State/Country

Race _____ Marital Status _____ No. of Children_____

Name of Spouse_____
(if applicable) (Last) (First) (Middle)

Nearest Relative _____ Phone #_____

& Address_____

UNDERGRADUATE EDUCATION (list in chronological order)

Name of School	City/State/Country	Date From / To	Degree

MEDICAL SCHOOL

(If Medical School is not LCME accredited complete Page 3 Non-LCME portion)

Name of School	City/State/Country	Date From / To	Degree

National Boards: Part I _____/_____ Part II_____/_____ Flex Examination _____/_____
(date taken) (score) (date taken) (score) (date taken) (score)

USMLE:

Step 1 _____/_____ Step II _____/_____ Step III_____/_____
(date taken) (score) (date taken) (score) (date taken) (score)

RESIDENCIES/FELLOWSHIPS

1st Year Postgraduate _____
Specialty (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

2nd Year Postgraduate _____
Specialty (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

3rd Year Postgraduate _____
Specialty (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

Fellowship _____
Specialty (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

Other Postgraduate Training _____
Specialty (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

RECOMMENDATION: List those asked to write letters of recommendation. Letters are to be sent directly to Dr. Kumar by writers). Please include name, address and position below:

(1) _____

_____

(2) _____

_____

(3) _____

_____

LICENSURE

Description	*State*	*Number*	*Date of Issue*	*Expires*
Medical//Dental License:				
DEA Number:				
Other (specify):				

PREVIOUS EDUCATIONAL OR RESEARCH EXPERIENCE, INCLUDING PUBLICATIONS:

_____

_____

_____

Honors: _____

_____

Extracurricular Activities: _____

Military Service: _____ by a court-martial?_____

(Nature of your discharge _____)

Health Status: Number of days lost last year due to illness_____Nature of Illness_____

Do you now abuse chemical substances*, as defined herein? ……. Yes___ No ___
Have you ever been convicted of any charge(s) related to or pertaining to chemical substance abuse*, or the possession, sale or distribution of illegal or legally controlled substances? …….. Yes___ No ___

*(Substance abuse is defined as using drugs for non-medical reasons in an attempt to influence the mind and body, to alter emotions and senses, and to escape reality. A drug can be considered as any substance, other than food and including alcohol, that has an effect on the central nervous system or other systems of the body.)

Other Charges and Violations:
Are you now under charges for any violation of law or have you ever been convicted of or forfeited collateral for any violation of law punishable by imprisonment of longer than one year, **except for:**
Traffic fines of $100 or less; any offense committed before your 18th birthday adjudicated in a juvenile court or under a youth offender law; any conviction for which the record has been expunged under federal or state? Yes___ No _

Is there any malpractice action or claim pending against you? ……..… Yes___ No _

Has there ever been a malpractice judgment against you or a monetary settlement of a claim against you? …. Yes___ No _

Have you ever been refused medical licensure? ……... Yes___ No _

Has your medical license ever been suspended or revoked? ……..… Yes___ No _

If you answered **"Yes"** to any of the above, give details. For each, give (1) date, (2) charge, (3) place, (4) court, (5) action taken. (Use additional sheets if necessary.) _____

INFORMATION REQUIRED OF NON-US CITIZENS AND GRADUATES FROM NON-LCME SCHOOLS

Visa Type and Status Type_____ Expiration date _____
(attach copy of VISA)

ECFMG Certificate No. _____ Date Issued_____ Valid Through_____
(attach copy of certificate)

FMGEMS: _____ Part I_____ Part II _____
(Date taken) (Score) (Score)

Flex Examination _____/_____
(Date taken) (Score)

ECFMG: _____/_____
(Date taken) (Score)

I CERTIFY that the answers to the foregoing questions are true and complete to the best of my knowledge and belief, and are made in good faith. I give UAB the right to contact all persons (organizations) named to gain information relevant to this application. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute sufficient grounds to UAB to terminate my fellowship without notice. I acknowledge by my signature that I have read and understand these statements.

_____ _____
Signature of Applicant (sign in ink) Date

Mailing Address:

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UAB Division of Nephrology
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Birmingham, AL 35294-0006

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