

TRANSPLANT NEPHROLOGY FELLOWSHIP APPLICATION

Date of application: _____ Beginning (month/year) _____

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

Social Security Number _____

Office Address _____

Fax # _____ Telephone _____ E-mail Address: _____

Home Address _____

E-mail Address: _____ Telephone _____

Birthplace: _____ Date of Birth: _____

Citizen of _____

If not U.S. Citizen, type of Visa and expiration date: _____

Name and contact information of next of kin _____

Relationship : _____ Address: _____ Phone # _____

Do you have any disabilities that may prevent you from performing the essential functions of a transplant fellow? Yes/No

If yes please explain: _____

UNDERGRADUATE EDUCATION (list in chronological order)

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

MEDICAL SCHOOL

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

USMLE:

Step I _____ / _____ Step II _____ / _____ /Step III _____ / _____
(date taken) (score) (date taken) (score) (date taken) (score)

Step II/CS _____ / _____
(date taken) (pass/fail)

COMLEX (if applicable): _____

INFORMATION REQUIRED OF GRADUATES FROM NON-US SCHOOLS

ECFMG Certificate No. _____ Date Issued _____ Valid Through _____
(attach copy of certificate)

RESIDENCY/FELLOWSHIP TRAINING

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 _____

PREVIOUS EDUCATIONAL OR RESEARCH EXPERIENCE, INCLUDING PUBLICATIONS: (may attach CV)

Academic and other honors: _____

Membership in scientific and professional organizations:

Extracurricular Activities: _____

NATIONAL BOARD EXAMINATIONS (dates taken and results)

LICENSURE

<u>Description</u>	<u>State</u>	<u>Number</u>	<u>Date of Issue</u>	<u>Expires</u>
Medical: _____	_____	_____	_____	_____
_____	_____	_____	_____	_____
DEA Number: _____	_____	_____	_____	_____
Other (specify): _____	_____	_____	_____	_____

LETTERS OF RECOMMENDATION:

Three letters of recommendation are required and should be sent directly to the UAB transplant fellowship program. One letter should be from your nephrology fellowship program director. Please include name, address and position of letter writers below:

- (1) _____

- (2) _____

- (3) _____

Military Service: (include rank, Branch of Service and Dates) _____

DISCLOSURES

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.)

CRIMINAL RECORD: Have you ever been convicted of a crime, other than a minor traffic violation Yes No
If yes please explain _____

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.) _____

COMMENTS (Please indicate any special experience or qualifications not covered in this form)

LONG TERM CAREER PLANS and RESEARCH INTERESTS

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

Please submit application by uploading on the website or in an email to

Jessica Hargrove
Program Coordinator
Transplant Nephrology Fellowship Program UAB Division of Nephrology
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1720 Second Avenue South
Birmingham, AL 352945-0006
Tel:205-934-7023
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