



Department of Neurology
395 W. 12th Avenue
7th Floor
Columbus, OH 43210
Phone: 614-293-6872
Fax: 614-293-2613

Please attach
recent photo

Fellowship Directors:
Miriam L. Freimer, M.D.
Clinical Neurophysiology

John. T. Kissel, M.D.
Neuromuscular Medicine

Application Requirements:

- 1. Completed application form
2. Transcript of medical school grades
3. Three letters of recommendation
4. Curriculum vitae
5. USMLE scores

(Please print or type)

Type of Fellowship desired: ( ) Clinical Neurophysiology ( ) Neuromuscular Medicine

APPLICATION FOR
CLINICAL NEUROPHYSIOLOGY/NEUROMUSCULAR MEDICINE
FELLOWSHIP

I hereby apply to the Ohio State University Medical Center Department of Neurology for
Clinical Neurophysiology/Neuromuscular Medicine Fellowship at the \_\_\_\_\_GY year level.

Full Name: \_\_\_\_\_ M.D. ( )
M.B.B.S. ( ) D.D.S ( ) D.O. ( ) M.B.B. Ch. ( ) D.M.D. ( )

DEMOGRAPHICS

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I can be best reached at Phone #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Other:

Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Citizenship: \_\_\_\_\_ U.S. Social Security #: \_\_\_\_\_

If not U.S. citizen, type of Visa held: \_\_\_\_\_

## MEDICAL LICENSE

### U.S. Unrestricted Medical License(s) (attach copy):

State: \_\_\_\_\_ No. \_\_\_\_\_

State: \_\_\_\_\_ No. \_\_\_\_\_

Has your license ever been suspended, revoked, or voluntarily surrendered? Have you ever been disciplined, in any way, by a licensing board? If so, please explain: \_\_\_\_\_

### U.S. Licensing Exams passed (attach copy of scores for each exam):

USMLE 1 \_\_\_\_\_ USMLE 2 \_\_\_\_\_ USMLE 3 \_\_\_\_\_ Other \_\_\_\_\_

### Medical License for International Medical Graduates (attach copies of each document):

ECFMG Certificate No: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ ( ) Interim ( ) Permanent

## EDUCATION INFORMATION

### Undergraduate Education:

Name of Institution: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

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

### Medical Education:

Medical School: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

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

### Internship Training:

Name of Institution: \_\_\_\_\_ Dates: \_\_\_\_\_

### Residency Training:

Name of Institution: \_\_\_\_\_ Dates: \_\_\_\_\_

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

**Other post M.D. training:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Membership in organization, professional, and other:** \_\_\_\_\_

\_\_\_\_\_

**REFERENCES:** Communications concerning professional and personal qualifications must be sent under separate cover directly to Miriam L. Freimer, M.D. or John T. Kissel, M.D. from at least three (3) physicians, preferably under whom you trained. **Letters of recommendation must be requested by the applicant.** List references below:

<u>Name</u>	<u>Title</u>	<u>Affiliation</u>	<u>Address and e-mail</u>
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever been suspended, expelled, or resigned from any medical school or hospital appointment; if so why?** \_\_\_\_\_

\_\_\_\_\_

**Extracurricular medical work not covered by the above questions:** \_\_\_\_\_

\_\_\_\_\_

APPLICANT'S NOTICE: Appointments can be made for one year only, subject to continuing advancement as opportunity and appearance permit, but this information is not obligated to extend any appointment beyond one year. Appointments are made for a specific service. No departmental chairperson can guarantee an appointment on service outside of his/her own department, but such interchange may be accomplished if and when it is mutually advantageous to all concerned. .

I certify that the information provided in this application is true and correct.

**SIGNATURE OF APPLICANT:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Return to: Karen Willman  
Program Coordinator  
The Ohio State University Medical Center  
Department of Neurology  
395 W. 12<sup>th</sup> Avenue, 7<sup>th</sup> Floor  
Columbus, OH 43210  
Fax: 614-293-2613  
karen.willman@osumc.edu

