

INTEGRATIVE MEDICINE FELLOWSHIP APPLICATION

PERSONAL INFORMATION

FULL NAME: _____ DATE: _____
Last First Middle

PREFERRED NAME: _____ DESIGNATED PRONOUNS: _____

DATE OF BIRTH: ____ - ____ - ____

ADDRESS: _____
Street Address Apt/Suite

City State Zip Code

E-MAIL: _____ PHONE: _____

MEDICAL EDUCATION

INSTITUTION: _____ CITY / STATE: _____

DATES ATTENDED FROM: _____ TO: _____

GRADUATE? YES NO

DEGREE: _____ DATE OF DEGREE: _____

HAVE YOU EVER HAD ANY UNPLANNED PROFESSIONALISM OR ACADEMIC ISSUES IN YOUR MEDICAL EDUCATION OR TRAINING THAT CAUSED AN INTERRUPTION OR EXTENSION? YES
 NO

Note: This section is not intended to solicit information about the applicant's health, disability, or family status.

POST-GRADUATE/RESIDENCY TRAINING



TRAINING TYPE: _____ SPECIALTY: _____

INSTITUTION: _____ CITY / STATE: _____

DATES ATTENDED FROM: _____ TO: _____

SETTING: _____

PROGRAM DIRECTOR: _____

SUPERVISOR: _____

ADDITIONAL TRAINING

TRAINING TYPE: _____ DEGREE/CERTIFICATE: _____

INSTITUTION: _____ CITY / STATE: _____

DATES ATTENDED FROM: _____ TO: _____

TRAINING TYPE: _____ DEGREE/CERTIFICATE: _____

INSTITUTION: _____ CITY / STATE: _____

DATES ATTENDED FROM: _____ TO: _____

TRAINING TYPE: _____ DEGREE/CERTIFICATE: _____

INSTITUTION: _____ CITY / STATE: _____

DATES ATTENDED FROM: _____ TO: _____

TRAINING TYPE: _____ DEGREE/CERTIFICATE: _____

INSTITUTION: _____ CITY / STATE: _____

DATES ATTENDED FROM: _____ TO: _____

ELIGIBLITY



MEDICAL LICENSURE YES NO

MEDICAL LICENSE EVER SUSPENDED/REVOKED/VOLUNTARILY TERMINATED? YES* NO

*IF YES, PLEASE EXPLAIN: _____

EVER NAMED IN MALPRACITCE SUIT? YES* NO

*IF YES, PLEASE EXPLAIN: _____

STATE(S) OF MEDICAL LICENSE(S): _____

BOARD CERTIFICATIONS: _____

ACLS/BLS CERTIFICATIONS: _____

HONORS & AWARDS

NAME: _____

DATE RECEIVED: _____

DESCRIPTION:

NAME: _____

DATE RECEIVED: _____

DESCRIPTION:

NAME: _____

DATE RECEIVED: _____

DESCRIPTION:

PROFESSIONAL MEMBERSHIPS

ORGANIZATION: _____

DATE: _____

ORGANIZATION: _____

DATE: _____

ORGANIZATION: _____

DATE: _____

PUBLICATIONS/POSTER PRESENTATIONS

OTHER

PLEASE TELL US ABOUT YOUR HOBBIES & INTERESTS:

PROFICIENT LANGUAGES: _____

PERSONAL STATEMENT

INCLUDING YOUR PROFESSIONAL BIO, WHAT APPEALS TO YOU ABOUT THE STUDY AND PRACTICE OF INTEGRATIVE MEDICINE, SKILLS AND STRENGTHS, AND CAREER GOALS?

DISCLAIMER

Applicant understands that this is an Equal Opportunity Employer and committed to excellence through diversity. In order to ensure this application is acceptable, please print or type with the application being fully completed in order for it to be considered.

Please complete each section EVEN IF you attach a resume.

I, the Applicant, certify that my answers are true and honest to the best of my knowledge. If this application leads to my eventual employment, I understand that any false or misleading information in my application or interview may result in my employment being terminated.

SIGNATURE _____ **DATE** _____

PRINT NAME _____