



16001 West Nine Mile Road
Southfield, MI 48075

FELLOWSHIP APPLICATION

(PLEASE PRINT OR TYPE)

Program you are applying for: _____ / _____
(Program) (Start Date)

Name: _____ S.S.# _____

Present Home Address: _____
Street City State Zip

Telephone Number(s): _____ / _____ / _____
Home Cell Pager

E-mail Address: _____

CITIZENSHIP:

- United States
- Permanent US Resident
- Other (please indicate which visa you plan to obtain)
 - J-1 Exchange Visitor
 - H1-b
 - Other (please specify) _____

Examinations/Certifications

ECFMG #: _____

BCLS: Yes No if yes attach copy

ACLS: Yes No if yes attach copy

USMLE Scores:

COMLEX Scores:

Part I _____

Part II _____

Part III _____

Board Certification:

Yes: _____ No: _____ Eligible: _____

Specialty of Certification: _____

Professional History

Medical School _____ Location _____

Graduation Date _____

Chronological history of all activity from your Medical School Graduation to the present. Please do not leave any gaps.
Please account for all time. Attach additional pages if necessary.

Dates		Place – Institution/Address/Country	Type of activity (Graduate training, studying, travel, research, professional practice, other employment)
From	To		
From	To		
From	To		
From	To		
From	To		

Please provide copies of the following documents with your application:

1. Curriculum Vitae
2. Three (3) letters of recommendation, (one of which must be from your Program Director)
3. USMLE or COMLEX transcripts
4. ECFMG Certificate (if applicable)
5. Medical School Diploma (with translation if in a foreign language)

Please forward completed application and all requested materials to:

PROVIDENCE HOSPITAL AND MEDICAL CENTERS
MEDICAL EDUCATION
16001 WEST NINE MILE ROAD
SOUTHFIELD, MICHIGAN 48075

ATTN: _____ Program
(Name of Fellowship)

Signature of Applicant

Date