University of Pennsylvania

Brain Injury Medicine Fellowship Application

Academic Year 2017-2018

Instructions:
1. The application and attachments should be emailed/mailed to:
   Angela Wheatcroft
2. Applicants must submit the following:
   a. Updated curriculum vitae
   b. Copies of all score sheets from USMLE/COMLEX, Board examinations or other examinations
   c. ECFMG certificate if applicable
   d. Three letters of recommendation, one of which must be from your current program director. Applicants can mail or have them sent or emailed directly to address below
   e. Personal Statement
   f. Additional comments as indicated in application

   Angela Wheatcroft
   Program Coordinator - Physical Medicine and Rehabilitation
   First Floor
   1800 Lombard Ave
   Philadelphia, PA 19146
   Angela.Wheatcroft@uphs.upenn.edu
   (215) 893-2676
Personal Information

Name ____________________________________________

Last    First    Middle

Mailing Address ____________________________________________

Street     Apt.#

City     State/Province     Zip     Country

Permanent Address ____________________________________________

(if different) Street     Apt.#

City     State/Province     Zip     Country

Cell/mobile phone: ____________________________

Email ____________________________________________

Social Security Number: ____________________________

Citizenship

U.S./other ____________________________

International applicants, please specify type of visa ____________________________

Undergraduate Education

________________________________________

Undergraduate institution and location

________________________________________

Type of degree, field of study, and date of degree
Medical Education

Medical School and location

Degree and dates of degree (From-To)

Examinations

USMLE I/COMLEX
  Pass Date: ______________ Score______________

USMLE2/COMLEX
  Pass Date: ______________ Score______________

Have you ever failed the USMLE I/COMLEX or USMLE2/COMLEX? Yes  No

CSA
  Pass Date: ______________

USMLE3 and/or other ______________________________
  Pass Date: ______________

ACGME Accredited Pre-Fellowship Residency

☐ Physical Medicine and Rehabilitation
☐ Neurology
☐ Psychology

Residency History

Residency Institution ________________________________

Years attended (e.g., 2000-2004) ______________

Other Residency ________________________________

Institution ________________________________

Years attended ______________

Date of Boards ____________________ Passed? Yes  No

All extensions or interruptions of my training in this or any other residency/fellowships are described completely in additional comments.
Medical Licensure (State/Lic#)
☐ Neither this nor any other state has ever placed or considered placing limitations upon my license to practice medicine.
☐ Current and/or prior limitations upon my license to practice medicine in this or any other state are described completely in additional comments.

Research Activity
☐ I have participated in research/scholarly activity. List of all research activity attached including published, accepted and submitted papers, presentations, and abstracts.
☐ I have not participated in research activity to date.

Basic Life Support Certification (BLS)

Basic Life Support (BLS) certification expiration date
☐ I am not currently certified in Basic Life Support (BLS).

Drug Enforcement Administration (DEA)

Drug Enforcement Administration (DEA) registration # and expiration date
☐ The Drug Enforcement Administration (DEA) has never limited or considered limiting my practice of prescribing medication.
☐ Current and/or prior limitations placed or considered by the Drug Enforcement Administration (DEA) regarding my practice of prescribing medication are described completely in additional comments.

Military, Other Governmental, or Non-Governmental Organization Participation or Obligation
☐ I have not participated in, and am not participating in or have an outstanding obligation to, any U.S. or non-U.S. military, other governmental, or non-governmental organizations.
☐ My current and/or prior participation in or obligation to all U.S. or non-U.S. military, other governmental, or non-governmental organizations is described completely in additional comments.

Medical Malpractice History
☐ I have no history of resolved, active, pending or currently considered medical malpractice actions
☐ All resolved, active, pending, and currently considered medical malpractice actions are described completely in additional comments.

Signature of applicant ____________________ Date ____________________