MEDICAL COLLEGE OF WISCONSIN / DEPARTMENT OF NEUROSURGERY
Milwaukee, WI

APPLICATION FORM

(If necessary, use additional sheets for information submitted)

(Print or Type)

Name **Last**	**First**	**Middle**		**Social Security Number**
Fellowship in Spinal Surgery				
Program		**Starting Date**		**Anticipated Program Completion Date**
Present Address: **Street**		**City**	**State**	**Zip**
Present Phone Numbers: **(DAY)**		**(EVENING)**		
Name and Phone Number of Person Through Whom I Can Always Be Contacted: (Name / Phone Number)				
Permanent Address of Person Through Whom I Can Always Be Contacted: (Street / City / State / Zip)				
DEA Certificate #	**CPR Certification Date**	**ACLS Certification Date**		**Medicare UPIN #**
DEA Expiration Date	**CPR Certification Expiration Date**	**ACLS Certification Expiration Date**		**NRMP#**

UNDERGRADUATE AND GRADUATE EDUCATION

COLLEGE(S)	Dates Attended		MAJOR(S)	DEGREE IF ANY
	From (MO / YR)	TO (MO / YR)		
A.				
Name and Address: City / State / Zip				
B.				
Name and Address: City / State / Zip				
C.				
Name and Address: City / State / Zip				

MEDICAL EDUCATION

COLLEGE(S)	Dates Attended		DATE OF GRADUATION	DEGREE
	From (MO / YR)	TO (MO / YR)		
A.				
Name and Address: City / State / Zip				
B.				
Name and Address: City / State / Zip				

GRADUATE MEDICAL EDUCATION IN U.S. ACCREDITED PROGRAMS

HOSPITAL(S)	Dates Attended		PROGRAM PROGRAM DIRECTOR
	From (MO / YR)	TO (MO / YR)	
A.			
Name and Address: City / State / Zip			
B.			
Name and Address: City / State / Zip			
C.			
Name and Address: City / State / Zip			

THE FOLLOWING INDIVIDUALS HAVE BEEN ASKED TO WRITE REFERENCES FOR ME:
These individuals should send letters directly to the Program Director

A. Name:	Title:
Institution:	Address:
B. Name:	Title:
Institution:	Address:
C. Name:	Title:
Institution:	Address:

Are you now or have you ever been involved in administration, professional or judicial proceedings in which malpractice on your part is or was alleged? If yes, give details.

List all convictions for any offense other than minor traffic violations and all pending criminal charges (no applicant will be denied a position because of a conviction for an offense or because of a pending criminal charge which is not substantially related to the circumstances of the position sought).

Have any disciplinary actions been initiated or are any currently pending against your medical license(s) in any state?

Have there been any actions taken against any privileges you currently or previously held?

Do you currently hold privileges at any health care institution or agency? (Include name and address)

Any medical license or DEA certificate revoked, suspended, denied, restricted, limited or issued/placed in a probational status or voluntarily relinquished?

CITIZENSHIP: U.S. ☐ **OTHER:** ☐

*__VISA STATUS: (If Applicable)__
☐ **PERMANENT**

☐ **TEMPORARY – SPECIFY:** ☐ **J-1** ☐ **H-1** ☐ **OTHER**

INTERNATIONAL MEDICAL SCHOOL GRADUATES

FMGEMS (Basic Medical Science)	**Number**	**Date**	**Score**
FMGEMS (Clinical Science)	Number	Date	Score
ECFMG English Exam	Number	Date	Score

*ECFMG CERTIFICATE: ☐ Standard or Interim ☐ Date Issued:
Expiration Date:

*FIFTH PATHWAY CERTIFICATE:
SCHOOL:
DATE:

National Board or USMLE Examination Number:			**FLEX Examination** Number:			**D.O. Examination** Number:	
	Date	Score		Date	Score	Date	Score
PART I			PART I				
STEP 1							
PART II			PART II				
STEP 2							
PART III			PART III				
STEP 3							

*MEDICAL LICENSES

State:	Number:	Date Issued:	Expiration Date:
State:	Number:	Date Issued:	Expiration Date:
State:	Number:	Date Issued:	Expiration Date:

NOTE: Wisconsin license is required and must be obtained prior to start of program.

This application will not be considered complete unless the three reference letters have been received by the Program Director, and all requested information is provided on this Application.

*Original or certified copies of these documents must be presented to MCW when pertinent, after acceptance, but prior to start of the training program.

The information provided in this application is true and complete.

Signature:

Date of Application:

PERSONAL STATEMENT: PLEASE TELL US WHY YOU'RE INTERESTED IN THE SPINE FELLOWSHIP AT THE MEDICAL COLLEGE OF WISCONSIN. You may also include professional interests, achievements, and plans, including specialty or sub specialty; anticipated geographic practice location; published papers; honors; professional and scientific organization memberships; family, household, and personal interests and activities. Any time since graduation from medical school not accounted for on page 2 should be accounted for here. Use additional sheet if necessary.

RETURN COMPLETED APPLICATION TO: spinefellows@MCW.edu