Doctors Hospital
OhioHealth

FELLOWSHIP APPLICATION FOR GRADUATE MEDICAL EDUCATION

Specialty	Emergency Medical Services

AOA &/or AMA #

Name (F/M/L)

Residency graduation (MM/YYYY)

Address

Emergency Contact

Home phone

Name

Cell phone

Telephone

E-mail

Relationship

APPLICATION INSTRUCTIONS

ONLY COMPLETE APPLICATIONS will be considered for review

REQUIRED MATERIALS

1. Completed application *with photo*
2. Curriculum Vitae
3. Cover letter *(indicating why you are interested in Doctors Hospital EMS)*
4. COMLEX &/or USMLE Board Scores *(parts I, II, & III)*
5. Program Director (PD) letter of good standing & verification of residency dates
   if a graduate you may submit letter from your program's GME office stating above
6. Three Letters of Recommendation:
   if a resident: one letter must be from PD with others from anyone with an EMS background (doctor, paramedic, EMT, etc)
   if a graduate: one letter must be from your current EM Medical Director
   ** Please have LoR writers place in sealed envelopes which you will return with this application **
7. ACLS / ATLS / BLS / PALS current certification *(provide copies please)*

EDUCATION BACKGROUND

RESIDENCY

Dates m/d/y - m/d/y

Specialty

Institution

Director, Medical Education

Address

City State Zip

Phone

please continue to next page

MEDICAL SCHOOL

Dates _____ (m/d/y) - _____ (m/d/y)

Institution _____

Address _____

City _____ State _____ Zip _____

OTHER EDUCATION

Dates _____ (m/d/y) - _____ (m/d/y)

Institution _____

Address _____

City _____ State _____ Zip _____

Degree _____

Certification _____

PRIVATE PRACTICE
(If applicable)

Dates _____ (m/d/y) - _____ (m/d/y)

Institution _____

Address _____

City _____ State _____ Zip _____

Position _____

Mark the appropriate box with an X	NO	YES	
Do you have a military obligation following your residency?			Branch _____
Do you have a public health obligation following your training?			
Have you practiced under another name?			Name used _____
Do you have a permanent State of Ohio medical license?			License # _____
Are you licensed to practice in another state?			State _____
an Ohio license will be required to begin Fellowship			License # _____
Has your license ever been suspended?			*Please explain conditions below*

I certify the information supplied is true, to the best of my knowledge, and in signing this application I waive the right under the federal disclosure law to see my recommendations and interview evaluations.

Signature _____

Date _____

Please return application materials appropriately to:

OhioHealth Doctors Hospital
Department of Graduate Medical Education
ATTN: Laura Epnett
EMS Fellowship Program Consultant
5100 West Broad St.
Columbus, OH 43228-1607