EMORY UNIVERSITY SCHOOL OF MEDICINE

Department of Medicine

Application for the Emory Complex and High-Risk Interventional Procedures (CHIP) Fellowship

RETURN COMPLETED APPLICATIONTO:
Tammy Runkle
Program Coordinator
tammy.runkle@emoryhealthcare.org

Instructions: Please complete this application and return via email to Ms. Tammy Runkle. The following items are also required with your application:

- An updated Curriculum Vitae detailing training, relevant experience, scholarly activity, awards and accomplishments
- A brief personal statement or cover letter outlining why you are interested in CHIP fellowship and your career goals
- Your USMLE/COMLEX transcript(s)
- Your ECFMG Certificate (if applicable)
- A recent photograph
- 3 letters of recommendation

Name_____Gender_____
Last First Middle

Email Address_____Date of Birth _____

Telephone Numbers: Cell_____Alternate_____

Mailing Address: _____

Licensed to practice in Medicine in State (s) of_____License No_____Expiration:_____

NPI Number: _____ AAMC ID_____Social Security Number: _____

USMLE _____ Step 1 _____ Step 2 _____ Step 3

COMLEX _____ Level 1 _____ Level 2 _____ Level 3

Are you a Foreign Medical Graduate? ☐ Yes ☐ No If Yes, do you have a ECFMG certificate? ☐ Yes ☐ No

Certificate Date_____Certificate Number _____

Are you a US Citizen? ☐ Yes ☐ No If no, list VISA type and expiration date: _____

Will you need VISA Sponsorship for fellowship? ☐ Yes ☐ No If yes, list VISA type:_____

Proof of U.S. citizenship or eligibility for U.S. employment will be required upon hire in accordance with regulation established pursuant to the Immigration Reform and Control Act of 1986.

Is funding from an outside source available? Source and amount of grant_____

EDUCATION

Premedical/preosteopathic_____ Dates_____ Degree_____

Other_____ Dates_____ Degree_____

Medical/Osteopathic_____ Dates_____ Degree_____

Internship_____ Dates_____ Degree_____
Hospital Program Director

RESIDENCY

_____ Dates_____ Degree_____
Hospital Program Director

_____ Dates_____ Degree_____
Hospital Program Director

FELLOWSHIP(S)

_____ Dates_____ Degree_____
Hospital Program Director

_____ Dates_____ Degree_____
Hospital Program Director

PREVIOUS EMPLOYMENT (professional or scientifically related)

Place_____ Dates_____

Duties_____

_____

Place_____ Dates_____

Duties_____

_____

Scholastic Societies_____

Honors and Awards_____

REFERENCES

Provide at least (3) three letters of reference. Reference letters should be received directly from your references, preferably via email. Please list contact info including email and preferably cell phone number.

1._____
Name Title Email/Phone number

2._____
Name Title Email/Phone number

3._____
Name Title Email/Phone number

Please answer the following questions. If you answer yes to any of the following, please include a letter with a detailed description, as well as supportive documentation.

Has your medical license ever been suspended/revoked/voluntarily terminated?
Have you been named in a malpractice case?
Is there anything in your history that would limit your ability to be licensed or would limit your ability to receive hospital privileges?
Have you ever been convicted of a misdemeanor?
Have you ever been convicted of a felony?

I certify that the information I have provided on this application is true and accurate:

Date: _____ Signature: _____