

APPLICATION FOR HOSPITAL MEDICINE FELLOWSHIP

ST. ELIZABETH HEALTH CENTER
1044 BELMONT AVENUE, YOUNGSTOWN, OHIO 44501
PHONE: 330-480-3344 FAX: 330-480-3777



**ST. ELIZABETH
HEALTH CENTER**
Humility of Mary Health Partners

ATTACH RECENT PHOTOGRAPH
PASSPORT SIZE

DATE OF APPLICATION: _____

APPLICANT INFORMATION:

1. NAME: _____
LAST FIRST MIDDLE

2A. MAILING ADDRESS:

STREET ADDRESS

CITY STATE ZIP

2B. PERMANENT ADDRESS: (IF DIFFERENT FROM THE MAILING ADDRESS)

STREET ADDRESS

CITY STATE ZIP

3. EMAIL ADDRESS: _____

4. PHONE NO: () _____ () _____ () _____
HOME WORK PAGER

5. BIRTHPLACE: _____
CITY STATE COUNTRY

6. VISA STATUS: H1b J1 GREEN CARD CITIZENSHIP

7. SOCIAL SECURITY NO: _____

8. US MEDICAL GRADUATE: _____ INTERNATIONAL MEDICAL GRADUATE: _____

8. ECFMG NO: _____ DATE ISSUED _____

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11A. EXAMINATIONS:

USMLE 1: _____ DATE: _____ SCORE: _____ NO. OF ATTEMPTS: _____

USMLE 2: _____ DATE: _____ SCORE: _____ NO. OF ATTEMPTS: _____

USMLE CS: _____ DATE: _____ SCORE: _____ NO. OF ATTEMPTS: _____

USMLE 3: _____ DATE: _____ SCORE: _____ NO. OF ATTEMPTS: _____

11B. OTHERS EXAMS:

NAME: _____ DATE: _____ SCORE: _____

NAME: _____ DATE: _____ SCORE: _____

NAME: _____ DATE: _____ SCORE: _____

NAME: _____ DATE: _____ SCORE: _____

12. MEDICAL LICENSURE:

STATE: _____ DATE: _____ NO: _____

STATE: _____ DATE: _____ NO: _____

STATE: _____ DATE: _____ NO: _____

13. AMERICAN SPECIALTY BOARD CERTIFICATION:

AMERICAN BOARD OF _____ DATE: _____

AMERICAN BOARD OF _____ DATE: _____

14. FELLOWSHIP:

14A: SPECIALTY: _____ INSTITUTION: _____

ADDRESS: _____
STREET STATE ZIPCODE

START DATE: _____ END DATE: _____

14B: SPECIALTY: _____ INSTITUTION: _____

ADDRESS: _____
STREET STATE ZIPCODE

START DATE: _____ END DATE: _____

15. APPOINTMENTS TO MEDICAL FACILITIES/HOSPITALS:

INSTITUTION: _____ LOCATION: _____

POSITION: _____ DATES: _____

INSTITUTION: _____ LOCATION: _____

POSITION: _____ DATES: _____

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16. ELECTIVES COMPLETED IN RESIDENCY (list no. of months or weeks)

- | | | |
|--|-----------------|-----------------|
| 1. Medical Intensive care | DURATION: _____ | HOSPITAL: _____ |
| 2. Coronary Intensive care | DURATION: _____ | HOSPITAL: _____ |
| 3. General Internal Medicine-inpatient | DURATION: _____ | HOSPITAL: _____ |
| 4. Medicine Consult service | DURATION: _____ | HOSPITAL: _____ |
| 5. Palliative care | DURATION: _____ | HOSPITAL: _____ |
| 6. Geriatrics | DURATION: _____ | HOSPITAL: _____ |
| 7. Clinical research | DURATION: _____ | HOSPITAL: _____ |
| 8. Quality improvement | DURATION: _____ | HOSPITAL: _____ |

Other Electives:

- | | | |
|-----------|-----------------|-----------------|
| 9. _____ | DURATION: _____ | HOSPITAL: _____ |
| 10. _____ | DURATION: _____ | HOSPITAL: _____ |
| 11. _____ | DURATION: _____ | HOSPITAL: _____ |
| 12. _____ | DURATION: _____ | HOSPITAL: _____ |
| 13. _____ | DURATION: _____ | HOSPITAL: _____ |
| 14. _____ | DURATION: _____ | HOSPITAL: _____ |
| 15. _____ | DURATION: _____ | HOSPITAL: _____ |
| 16. _____ | DURATION: _____ | HOSPITAL: _____ |

17. REFERENCE:

- | | |
|---------------------------|------------------------|
| 1. NAME: _____ | TITLE: _____ |
| INSTITUTION: _____ | EMAIL: _____ |
| PAGER: _____ | PHONE NO. _____ |
| 2. NAME: _____ | TITLE: _____ |
| INSTITUTION: _____ | EMAIL: _____ |
| PAGER: _____ | PHONE NO. _____ |
| 3. NAME: _____ | TITLE: _____ |
| INSTITUTION: _____ | EMAIL: _____ |
| PAGER: _____ | PHONE NO. _____ |

_____ I here by waive access to the above letter and will so inform the authors.

* Check one

_____ I Desire access to the above letters and will so inform the authors.

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18. SERVICE OBLIGATIONS: (National Health Service Corps, Armed Forces Scholarship, state programs etc.)

1. I am not required to fulfill any obligations _____
2. I am committed to fulfill a service obligation: Start date: _____ End Date: _____ No. Of yrs: _____

19. QUESTIONNAIRE: Please check the appropriate answers.

1. Have you ever been convicted of, been fined and/or sentenced for any Criminal offense (misdemeanor or felony) or have you ever plead guilty or no "contest to any criminal offense (misdemeanor or felony)? Yes _____ No _____
2. Have you ever been involved in malpractice? Yes _____ No _____
3. Has your professional license ever been suspended or revoked? Yes _____ No _____

INSTRUCTIONS:

1. Please attach a recent color photograph (taken in the last 6 months)
2. Before completing this application, read all items carefully, **TYPE OR PRINT IN INK.**
3. Please provide a valid email address, as correspondence will be via email. (3)
4. Give complete answers. If additional space is needed, attach 8 1/2 by 11 sheets
5. All material must be received before processing of application can be completed.
6. References: Please provide information of 3 references with whom you have had professional affiliation or training during the last five years. One of the references must be the program director of the residency program. (14)
7. **Please send the completed application form with the curriculum vitae, personal statement and 3 letters of recommendation (one from the program director) to the address below: St. Elizabeth Health Center. Department of Internal Medicine. Hospital Medicine Fellowship Program, 1044 Belmont Avenue, Youngstown. Ohio. 44501**
8. Please save a copy of this application form and other requirements for future reference.

I have read and understand the instructions for the completion of this application, I certify that the information submitted on this application form is complete and correct to the best of my knowledge: I understand that any false or missing information may disqualify me for this position.

Signature: _____ Date: _____

NOTE: SIGNATURE AND DATE ON THE APPLICATION MUST BE ORIGINAL

