Miami Children's Health System/Nicklaus Children's Hospital
Pediatric Neurosurgery Fellowship Program Application

Application for Fellowship for Academic Year 20__ - 20__

PERSONAL DATA:

Name:	
Current Mailing Address:	
Permanent Mailing Address:	
Telephone Numbers:	**Day:**
	Evening:
Email Address:	
Social Security Number:	
Date of Birth:	
Place of Birth:	
☐ **U.S.** ☐ Permanent ☐ J-1 ☐ Other	

EDUCATION:

Degrees	School	Date Completed
Undergraduate:		
Medical School:		
Other:		

RESIDENCY INFORMATION:

Title	Institution	Date Completed

USMLE:	Step 1:	
(type in score)	Step 2:	CSA:
	Step 3:	
Licensure:	State:	Year:

Awards, Honors, and Memberships in Professional Societies:

Academic and Committee Memberships:

PROFESSIONAL REFERENCES: (List Three)

(1)
(2)
(3)

CHECKLIST FOR COMPLETION OF APPLICATION:

- ☐ Completed and signed application
- ☐ Curriculum Vitae
- ☐ Personal Statement (one page)
- ☐ Medical School Diploma copy
- ☐ Residency Diploma copy (if applicable)
- ☐ Three (3) letters of recommendation (one must be written by the Director of your Residency Program or Chair of your Department; must be in sealed envelopes)
- ☐ Photo

_____ _____

Signature of Applicant Date

Please complete the application electronically. Print, sign, and email the application to:

Kari Bollerman
Email: kari.bollerman@nicklaushealth.org