



**Nicklaus
Children's
Hospital**

MIAMI CHILDREN'S HEALTH SYSTEM 

**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:	
<input type="checkbox"/> U.S. <input type="checkbox"/> Permanent <input type="checkbox"/> J-1 <input type="checkbox"/> Other	

EDUCATION:

<u>Degrees</u>	<u>School</u>	<u>Date Completed</u>
Undergraduate:		
Medical School:		
Other:		

RESIDENCY INFORMATION:

<u>Title</u>	<u>Institution</u>	<u>Date Completed</u>

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 (preferred) or fax the application to:

Judy Arevalo
Email: judy.arevalo@mch.com
Fax: 305-663-8490