

**ALBERT EINSTEIN MEDICAL CENTER
INTERVENTIONAL CARDIOLOGY FELLOWSHIP
APPLICATION FORM**



(Please print or type)

Date of Application _____

Name _____
(Last) (First) (Middle)

Social Security Number _____

Present Address _____
Street City State Zip Code

Permanent Address _____
Street City State Zip Code

Current Telephone Daytime (_____) _____

Evening (_____) _____

Email _____

Date of Birth _____

Citizenship _____

Visa Status _____

EDUCATIONAL BACKGROUND

High School _____

(From) _____ (To) _____

College _____

(From) _____ (To) _____

Medical School _____

(From) _____ (To) _____

INTERNSHIP AND RESIDENCY

Internship: Type _____ Hospital _____ (From) _____ (To) _____

Residency: Type _____ Hospital _____ (From) _____ (To) _____

Cardiology Fellowship: Hospital _____ (From) _____ (To) _____

RESEARCH EXPERIENCE *(List number of manuscripts, case reports, abstracts, and indicate whether published, accepted or submitted. Detail titles in CV).*

HONORS & AWARDS

WORK EXPERIENCE: *(Please account for any interruptions in education or post-graduate training).*

FUTURE CAREER PLANS IN MEDICINE: *(Indicate subspecialty, i.e., non-invasive, invasive or undecided and type of practice i.e., academic, university affiliated, private practice, etc.)*

ABIM BOARD CERTIFICATION

_____	_____	_____
<small>(Date Taken)</small>	<small>(Score)</small>	<small>(No. of Attempts)</small>

USMLE RESULTS

Part I	_____	_____	_____
	<small>(Date)</small>	<small>(Raw Score)</small>	<small>(No. of Attempts)</small>
Part II	_____	_____	_____
	<small>(Date)</small>	<small>(Raw Score)</small>	<small>(No. of Attempts)</small>
Part III (if taken)	_____	_____	_____
	<small>(Date)</small>	<small>(Raw Score)</small>	<small>(No. of Attempts)</small>

State or Country in which licensed _____ State License # _____

Persons from whom you have requested letters of recommendation:

1. _____
2. _____
3. _____

Your completed application form and supporting documents* (medical school transcript, USMLE official score report, curriculum vitae, personal statement and three (3) letters of recommendations, in sealed envelopes with author's signature on outside of envelope seal) should be sent in one package to:

Mr. Philip J. Walsh
Fellowship Programs Coordinator
Department of Medicine
Albert Einstein Medical Center
5401 Old York Road, Suite 363
Philadelphia, PA 19141-3025

Signature of Applicant: _____ Date: _____