

**APPLICATION FOR FELLOWSHIP IN MATERNAL-FETAL MEDICINE**  
**YEAR 2005**

Full Name \_\_\_\_\_

Present Address \_\_\_\_\_ Permanent Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone No. \_\_\_\_\_ Telephone No. \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Fax No. \_\_\_\_\_

\*Date of Birth \_\_\_\_\_ \*Sex M \_\_\_\_\_ F \_\_\_\_\_

\*Married: Yes [ ] No [ ] \* Number of Children: [ ] Citizen: † Yes [ ] No [ ]

† "No" give alien registration \_\_\_\_\_ Type of Visa \_\_\_\_\_ Date of Entry \_\_\_\_\_

**EDUCATION** (Include High School, College, Medical School, Other)

|    | School | Dates Attended | Year Graduated | Degree | Major |
|----|--------|----------------|----------------|--------|-------|
| 1. | _____  | _____          | _____          | _____  | _____ |
| 2. | _____  | _____          | _____          | _____  | _____ |
| 3. | _____  | _____          | _____          | _____  | _____ |
| 4. | _____  | _____          | _____          | _____  | _____ |

**TRAINING**

|    | Hospital | Years | Service | Title |
|----|----------|-------|---------|-------|
| 1. | _____    | _____ | _____   | _____ |
| 2. | _____    | _____ | _____   | _____ |
| 3. | _____    | _____ | _____   | _____ |
| 4. | _____    | _____ | _____   | _____ |

If graduate of foreign medical school, give ECFMG Number \_\_\_\_\_

Visa Status \_\_\_\_\_

**NON-SCHOLASTIC EXPERIENCE:** (Include Military Service, Research, Employment)

| Employer/Supervisor/Company | Position | Years | Reason for Leaving |
|-----------------------------|----------|-------|--------------------|
| 1. _____                    | _____    | _____ | _____              |
| 2. _____                    | _____    | _____ | _____              |
| 3. _____                    | _____    | _____ | _____              |
| 4. _____                    | _____    | _____ | _____              |

**PUBLICATIONS:** (Use additional space if required)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Diplomate of National Board of Medical Examiners: Yes ? No ?

State Licensed to Practice: \_\_\_\_\_ Number \_\_\_\_\_ DEA No. \_\_\_\_\_

Board of Eligibility/Certification (Dates) \_\_\_\_\_

Highlights of Training

| Strengths | Weaknesses |
|-----------|------------|
| 1. _____  | 1. _____   |
| 2. _____  | 2. _____   |
| 3. _____  | 3. _____   |

**REFERENCES:**

Give names and addresses of at least three of your professors or teachers in medicine or physicians under whom you have worked as references.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**RETURN APPLICATION TO:**

Jonni Buchwald  
Department of Obstetrics & Gynecology  
Division of Maternal Fetal Medicine  
Columbia University, College of Physicians & Surgeons  
622 West 168<sup>th</sup> Street, PH 16-66  
New York, New York 10032

\*The New York Human Rights Law Prohibits Discrimination Because of Age or Sex: the Federal Age Discrimination in Employment Act of 1967 Prohibits Discrimination on the basis of Age with Respect to Individuals Who are at Least 40 but Less than 65 years of age. Columbia University prohibits discrimination on the basis of marital status.