| Wright State University Boonshoft School of MedicineAcute Care Surgery/Surgical Critical Care fellowship | | | | |
| --- | --- | --- | --- | --- |
| Applicant Information | | | | |
| Name: | | | | |
| Date of birth: | SSN: | Phone: | | |
| Current address: | | | | |
| City: | State: | ZIP Code: | | |
| Home Phone: | Cell Phone: | Preferred: Choose an item. | | |
| Email address: | | | | |
| Birth Place: | Birth Date: | Citizenship: | | |
| Undergratuate Education | | | | |
| **Undergraduate School:** | | | | |
| Address: | | Dates Attended: | | |
| City: | State: | Zip Code: | | |
| Degree: | | | | |
| **Undergraduate School:** | | | | |
| Address: | | Dates Attended: | | |
| City: | State: | Zip Code: | | |
| Degree: | | | | |
| Medical Education | | | | |
| **Medical School**: | | | | |
| Address: | | Dates Attended: | | |
| City: | State: | ZIP Code: | | |
| Accredited? Choose an item. | Country: | | | |
| **Medical School:** | | | | |
| Address: | | | | |
| City: | State: | ZIP Code: | | |
| Accredited? Choose an item. | Country: | Dates Attended: | | |
| Post graduate training | | | | |
| **Institution:** | | | | |
| Address: | | Dates: | | |
| City: | State: | Zip Code: | | |
| Specialty: | Specialty Board Certified/Admissible: Choose an item. | | | |
| Country: | | | | |
| **Institution:** | | | | |
| Address: | | Dates: | | |
| City: | State: | Zip Code: | | |
| Specialty: | Specialty Board Certified/Admissible: Choose an item. | | | |
| Country: | | | | |
| **Institution:** | | | | |
| Address: | | Dates: | | |
| City: | State: | Zip Code: | | |
| Specialty: | Specialty Board Certified/Admissible: Choose an item. | | | |
| **Institution:** | | | | |
| Address: | | Dates: | | |
| City: | State: | Zip Code: | | |
| Specialty: | Specialty Board Certified/Admissible: Choose an item. | | | |
| fellowships | | | | |
| **Institution:** | | | | |
| Address: | | Dates: | | |
| City: | State: | Zip Code: | | |
| Specialty: | Specialty Board Certified/Admissible: Choose an item. | | | |
| **Institution:** | | | | |
| Address: | | Dates: | | |
| City: | State: | Zip Code: | | |
| Specialty: | Specialty Board Certified/Admissible: Choose an item. | | | |
| Medical License | | | | |
| Name (as it appears on license): | Number: | | State: | Expiration: |
|  |  | |  |  |
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|  |  | |  |  |
| military service | | | | |
| Branch: | Current Status: | | | |
| References (Individuals sending a LOR) | | | | |
| Name: | Address: | | Phone Number: | |
|  |  | |  | |
|  |  | |  | |
|  |  | |  | |
| Disclosure InfoMation | | | | |
| 1. Do you have any restrictions limiting your ability to fulfill an academic schedule or assignment? | | | Choose an item. | |
| 1. Has your license to practice medicine, in any jurisdiction, ever been voluntarily or involuntarily limited, suspended, revoked, restricted, denied or currently being challenged? | | | Choose an item. | |
| 1. Has your hospital or facility medical staff membership or have your hospital professional privileges ever been voluntarily or involuntarily suspended, limited, denied or surrendered for reasons related to professional competence or conduct, other than on-completion of medical records or are any such actions pending? | | | Choose an item. | |
| 1. Has any hospital ever denied your request for medical staff privileges? | | | Choose an item. | |
| 1. Have you ever resigned or been asked to resign from a medical staff or a professional society? | | | Choose an item. | |
| 1. Have you ever withdrawn your application for appointment, reappointment or clinical privileges or resigned from the medical staff before a decision was made by the medical or health care facility’s governing board regarding the application/privileges? | | | Choose an item. | |
| 1. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed? | | | Choose an item. | |
| 1. Have you ever been the subject of focused individual monitoring at any hospital or healthcare facility? | | | Choose an item. | |
| 1. Have you ever been convicted of a felony? | | | Choose an item. | |
| 1. Have you ever been party to any malpractice liability claims, suits and/or settlements? *If yes, please attach an explanation.* | | | Choose an item. | |
| 1. Have you ever had a professional liability insurance declined, cancelled, issued on special terms or renewal refused (for reasons other than the carrier’s termination of operations in your state)? | | | Choose an item. | |
| 1. Have you ever been placed on probation or asked to resign an internship or residency training program? | | | Choose an item. | |
| 1. Have you ever been the subject of an investigation or have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance? | | | Choose an item. | |
| 1. Has your DEA license or state narcotics registration ever been voluntarily or involuntarily refused, limited, suspended, revoked or currently being challenged? | | | Choose an item. | |

**Please include the following with your application:**

Copy of CV, Current Photo and A Personal Statement/Career Goals (do not exceed 700 words)

***Your application will be considered complete after receiving:***

*Completed Application*

*Copy of CV*

*Current Photo*

*Three (3) Letters of Recommendation from the individuals listed above*

*Copy of ECFMG*

**For more information, please contact:**

Melissa Keller, Fellowship Coordinator

Department of Surgery

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