

**Department of Neurology**

**Fellowship Application**

**Headache Division**

**Program Director: Ann Pakalnis, M.D.**

**Associate Program Director: Kevin Weber, M.D.**

|  |  |
| --- | --- |
| **APPLICATION FOR** |  |

 ACADEMIC YEAR

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NAME** |  |  |  |  |  |  |
|  | FIRST |  | MIDDLE INITIAL |  | LAST |  |

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| **DEGREE** |  | MD |  |  | DO |

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| **DATE OF BIRTH** |  |  | **PLACE OF BIRTH** |  |

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| --- | --- |
| **ADDRESS** |  |

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|  |  |  |  |  |
| CITY |  | STATE |  | ZIP CODE |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TELEPHONE** |  |  | **E-MAIL** |  |

|  |  |  |  |  |
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| **CITIZENSHIP** |  |  | **VISA TYPE** |  |
|  |  |  |  | IF APPLICABLE |

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| --- | --- | --- | --- | --- | --- |
| **MEDICAL** |  |  |  |  |  |
| **LICENSURE** | STATE |  | NUMBER |  | EXPIRATION DATE |
|  |  |  |  |  |  |
|  | STATE |  | NUMBER |  | EXPIRATION DATE |

**HAS YOUR LICENSE EVER BEEN SUSPENDED, REVOKED, OR VOLUNTARILY SURRENDERED? HAVE YOU EVER BEEN DISCIPLINED, IN ANY WAY, BY A LICENSING BOARD? IF YES, PLEASE EXPLAIN ON A SEPARATE SHEET.**

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| --- | --- | --- | --- | --- | --- |
|  |  | NO |  |  | YES  |

|  |  |  |  |  |  |
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| **EXAMINATION**  |  |  |  |  |  |
| **SCORES** | USMLE 1 / COMLEX I |  | USMLE 2 / COMLEX II |  | USMLE 3 / COMLEX III |

|  |  |  |  |  |
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| **ECFMG**  |  |  | **EXPIRATION** |  |
| **NUMBER** | IF APPLICABLE  |  | **DATE** | IF APPLICABLE |

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| **UNDERGRADUATE**  |  |  |  |

**EDUCATION** DEGREE

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|  |  |  |  |  |
| CITY |  | STATE |  | COUNTRY |

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| **GRADUATE**  |  |  |  |

**SCHOOL** DEGREE

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|  |  |  |  |  |
| CITY |  | STATE |  | COUNTRY |
| **MEDICAL** |  |

**SCHOOL**

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| CITY |  | STATE |  | COUNTRY |

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| **INTERNSHIP** |  |

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|  |  |  |  |  |
| CITY |  | STATE |  | PROGRAM DIRECTOR |

|  |  |
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| **NEUROLOGY** |  |

**RESIDENCY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| CITY |  | STATE |  | PROGRAM DIRECTOR  |
|  |  |

PROGRAM ADDRESS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **BOARD** |  |  |  |  |  |
| **CERTIFICATION** | BOARD  |  | CERTIFICATE NUMBER |  | EXPIRATION DATE |
|  |  |  |  |  |  |

**REFERENCES**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| NAME |  | TITLE / INSTITUTION |  |
|  |  |  |  |
| TELEPHONE |  | E-MAIL |  |

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|  |  |  |  |
| NAME |  | TITLE / INSTITUTION |  |
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| TELEPHONE |  | E-MAIL |  |

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| NAME |  | TITLE / INSTITUTION |  |
|  |  |  |  |
| TELEPHONE |  | E-MAIL |  |

**HAVE YOU EVER BEEN SUSPENDED, EXPELLED, OR RESIGNED FROM ANY MEDICAL SCHOOL, RESIDENCY, OR HOSPITAL APPOINTMENT? IF YES, PLEASE EXPLAIN ON A SEPARATE SHEET.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | NO |  |  | YES  |

**I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT.**

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|  |  |  |  |
|  | APPLICANT SIGNATURE |  | DATE |

**PLEASE EMAIL THIS APPLICATION WITH THE SUPPORTING DOCUMENTS TO**

**Karen Willman**

**FELLOWSHIP PROGRAM COORDINATOR**

**THE OHIO STATE UNIVERSITY MEDICAL CENTER**

**DEPARTMENT OF NEUROLOGY**

**395 W. 12TH AVENUE, 7TH FLOOR**

**COLUMBUS, OH 43210**

**614-293-6872**

**karen.willman@osumc.edu**

**SUPPORTING DOCUMENTS**

* **CV**
* **PERSONAL STATEMENT**
* **PHOTO**
* **A COPY OF MEDICAL SCHOOL DIPLOMA**
* **A COPY OF ECFMG CERTIFICATE (IF APPLICABLE)**
* **CERTIFICATE OF COMPLETION OF AN ACGME ACCREDITED NEUROLOGY RESIDENCY PROGRAM OR, IF CURRENTLY A RESIDENT, A LETTER FROM THE NEUROLOGY RESIDENCY PROGRAM DIRECTOR INDICATING GOOD STANDING**
* **USMLE OR COMLEX SCORES**
* **THREE LETTERS OF REFERENCE (ONE MUST BE FROM CURRENT RESIDENCY PROGRAM DIRECTOR )**
* **PROOF OF US CITIZENSHIP, PERMANENT RESIDENCY OR VISA STATUS**
* **A COPY OF NEUROLOGY BOARD CERTIFICATE (IF APPLICABLE)**
* **A COPY OF OHIO STATE MEDICAL LICENSE (IF AVAILABLE)**

