# MEDICAL COLLEGE OF WISCONSIN / DEPARTMENT OF NEUROSURGERY
## Milwaukee, WI

## APPLICATION FORM

(If necessary, use additional sheets for information submitted)

**(Print or Type)**

| | | | | |
|---|---|---|---|---|
| | | | | |
| **Name** **Last** | **First** | **Middle** | | **Social Security Number** |
| **Fellowship in Spinal Surgery** | | | | |
| **Program** | | **Starting Date** | | **Anticipated Program Completion Date** |
| | | | | |
| **Present Address:** **Street** | | **City** | **State** | **Zip** |
| | | | | |
| **Present Phone Numbers:** **(DAY)** | | **(EVENING)** | | |
| | | | | |
| **Name and Phone Number of Person Through Whom I Can Always Be Contacted: (Name / Phone Number)** | | | | |
| | | | | |
| **Permanent Address of Person Through Whom I Can Always Be Contacted: (Street / City / State / Zip)** | | | | |
| | | | | |
| **DEA Certificate #** | **CPR Certification Date** | **ACLS Certification Date** | | **Medicare UPIN #** |
| | | | | |
| **DEA Expiration Date** | **CPR Certification Expiration Date** | **ACLS Certification Expiration Date** | | **NRMP#** |

## UNDERGRADUATE AND GRADUATE EDUCATION

| COLLEGE(S) | Dates Attended | | MAJOR(S) | DEGREE IF ANY |
|---|---|---|---|---|
| | From (MO / YR) | TO (MO / YR) | | |
| A. | | | | |
| **Name and Address: City / State / Zip** | | | | |
| B. | | | | |
| **Name and Address: City / State / Zip** | | | | |
| C. | | | | |
| **Name and Address: City / State / Zip** | | | | |

## MEDICAL EDUCATION

| COLLEGE(S) | Dates Attended | | DATE OF GRADUATION | DEGREE |
|---|---|---|---|---|
| | From (MO / YR) | TO (MO / YR) | | |
| A. | | | | |
| **Name and Address: City / State / Zip** | | | | |
| B. | | | | |
| **Name and Address: City / State / Zip** | | | | |

## GRADUATE MEDICAL EDUCATION IN U.S. ACCREDITED PROGRAMS

| HOSPITAL(S) | Dates Attended | | PROGRAM<br>PROGRAM DIRECTOR |
|---|---|---|---|
| | From<br>(MO / YR) | TO<br>(MO / YR) | |
| A. | | | |
| **Name and Address: City / State / Zip** | | | |
| B. | | | |
| **Name and Address: City / State / Zip** | | | |
| C. | | | |
| **Name and Address: City / State / Zip** | | | |

**THE FOLLOWING INDIVIDUALS HAVE BEEN ASKED TO WRITE REFERENCES FOR ME:**
**These individuals should send letters directly to the Program Director**

| | |
|---|---|
| A. Name: | Title: |
| Institution: | Address: |
| B. Name: | Title: |
| Institution: | Address: |
| C. Name: | Title: |
| Institution: | Address: |

**Are you now or have you ever been involved in administration, professional or judicial proceedings in which malpractice on your part is or was alleged? If yes, give details.**

**List all convictions for any offense other than minor traffic violations and all pending criminal charges (no applicant will be denied a position because of a conviction for an offense or because of a pending criminal charge which is not substantially related to the circumstances of the position sought).**

**Have any disciplinary actions been initiated or are any currently pending against your medical license(s) in any state?**

**Have there been any actions taken against any privileges you currently or previously held?**

**Do you currently hold privileges at any health care institution or agency? (Include name and address)**

**Any medical license or DEA certificate revoked, suspended, denied, restricted, limited or issued/placed in a probational status or voluntarily relinquished?**

**CITIZENSHIP: U.S.** ☐ **OTHER:** ☐

*__VISA STATUS: (If Applicable)__
☐ **PERMANENT**

☐ **TEMPORARY – SPECIFY:** ☐ **J-1** ☐ **H-1** ☐ **OTHER**

## INTERNATIONAL MEDICAL SCHOOL GRADUATES

| | | | |
|---|---|---|---|
| FMGEMS (Basic Medical Science) | **Number** | **Date** | **Score** |
| FMGEMS (Clinical Science) | Number | Date | Score |
| ECFMG English Exam | Number | Date | Score |

*ECFMG CERTIFICATE: ☐ Standard or Interim ☐ Date Issued:
Expiration Date:

*FIFTH PATHWAY CERTIFICATE:
SCHOOL:
DATE:

| **National Board or USMLE Examination** Number: | | | **FLEX Examination** Number: | | | **D.O. Examination** Number: | |
|---|---|---|---|---|---|---|---|
| | Date | Score | | Date | Score | Date | Score |
| PART I | | | PART I | | | | |
| STEP 1 | | | | | | | |
| PART II | | | PART II | | | | |
| STEP 2 | | | | | | | |
| PART III | | | PART III | | | | |
| STEP 3 | | | | | | | |

## *MEDICAL LICENSES

| | | | |
|---|---|---|---|
| State: | Number: | Date Issued: | Expiration Date: |
| State: | Number: | Date Issued: | Expiration Date: |
| State: | Number: | Date Issued: | Expiration Date: |

**NOTE: Wisconsin license is required and must be obtained prior to start of program.**

This application will not be considered complete unless the three reference letters have been received by the Program Director, and all requested information is provided on this Application.

*Original or certified copies of these documents must be presented to MCW when pertinent, after acceptance, but prior to start of the training program.

The information provided in this application is true and complete.

Signature:

Date of Application

**PERSONAL STATEMENT:** Professional interests, achievements and plans, including specialty or subspecialty; anticipated geographic practice location; published papers; honors; professional and scientific organizations memberships; family, household and personal interests and activities. Any time since graduation from medical school not accounted for on page 2 should be accounted for here. Use additional sheet if necessary.

Signature:

Date of Application:

**RETURN COMPLETED APPLICATION TO: NSGadminpool@MCW.edu**