University Hospitals Cleveland Medical Center

Rainbow Babies & Children's

APPLICATION FOR EEG COURSE

Full Name: _____ Highest Degree: _____

Date of Birth: _____ Current Position/Title: _____

Which session of the EEG Course will you attend? February ☐ (year:) July ☐ (year:)

Are you interested in staying after the course for our 1-year Research Scholar Program? (no-stipend)

Yes ☐ No ☐

DEMOGRAPHICS

Present Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Telephone: _____ Cell Phone: _____

E-Mail Address: _____ Fax: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Other:

Citizen of: _____

Green Card # (if applicable): _____ J-1 Visa # (if applicable): _____

U.S. Licensing Exams passed (attach a copy of scores for each exam, if available):

ECFMG English: _____ Clinical Skills Assessment: _____

USMLE 1 _____ USMLE 2 _____ USMLE 3 _____

English Proficiency Exams passed (attach a copy of scores for each exam taken):

TOEFL: _____ IELTS: _____ OET: _____

*If above tests results are unavailable, the candidate needs a phone assessment by the coordinator. Please set up a time for a phone interview.

Medical License/International Medical Graduates: (attach copies of each document)

ECFMG Certificate No. _____ Type of Visa: _____ Hold: ☐ Needed: ☐

FUTURE CAREER PLAN:

_____

_____

MEDICAL or POSTGRADUATE EDUCATION and TRAINING

Institution: _____

From: _____ To: _____ Degree: _____

Type of Post Graduate Education:

_____

_____

Special Training in Academics or Hospital setting:

_____

_____

_____

Publications & Grants:

_____

_____

_____

_____

SIGNATURE OF APPLICANT: _____ DATE: _____

Return to:

Attn: Tamika Cammon
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Tamika.Cammon@uhhospitals.org (Coordinator)
Jun.Park@Uhhospitals.org (Director)