University Hospitals Cleveland Medical Center

Rainbow Babies & Children's

APPLICATION FOR EEG COURSE

Full Name: _____ Highest Degree: _____

Date of Birth: _____ Social Security # (if available): _____

Which session of the EEG Course will you attend? February ☐ July ☐

Are you interested in staying after the course for our 1 year Research Scholar Program? (non-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 copy of scores for each exam if applicable):

ECFMG English: _____ TOEFL: _____ Clinical Skills Assessment: _____

USMLE 1 _____ USMLE 2 _____ USMLE 3 _____

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

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

MEDICAL or POSTGRADUATE EDUCATION and TRAINING

Institution: _____

From: _____ To: _____ Degree: _____

Type of Post Graduate Education:

_____

_____

Special Training in Academics or Hospital setting (not already):

_____

_____

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Publications & Grants

_____

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_____

SIGNATURE OF APPLICANT: _____ DATE: _____

Return to:

Attn: Tarrika Allen
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Cleveland, OH 44106-5040
Tarrika.Allen@uhhospitals.org