UNIVERSITY OF FLORIDA
DEPARTMENT OF NEUROSURGERY
ENDOVASCULAR SURGICAL NEURORADIOLOGY
FELLOWSHIP APPLICATION

FELLOWSHIP START

JULY 1 2014

Name:_____
(Last) (First) (Middle)

Have you ever changed your name through marriage, naturalization or action of a **court or have you been known by any other names?** If yes; list original name(s) ☐ YES ☐ NO

_____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number _____

Mailing address:

_____
(Street and number or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

Permanent address:

_____
(Street and number) (City) (State/Province) (Zip/Postal Code) (Country)

Telephone (_____)_____ (_____)_____
(Primary: Area Code/Phone Number) (Alternate: Area Code/Phone Number)

E-mail address: _____

Demographics:

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Sex: ☐ Male ☐ Female

Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received

Postgraduate Training: In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present (Internship/Residency/Fellowship).

Program Name and Full Mailing Address	Specialty Area	From: mm/yy	To: mm/yy	Did you receive credit? Yes or No

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NEUROENDOVASCULAR FELLOWSHIP APPLICATION

SUPPORTING DOCUMENTS	
Enclosed are the following: ☐ Photo ☐ CV/Resume ☐ Documentation of 100+ cerebral angiograms ☐ Two (2) Letters of Reference ☐ Personal Statement I understand that my file will not be reviewed until you have received **all of the above** documents.	I certify that the information in this application is true and complete and that I have not withheld information that might affect my qualifications for a research fellowship in Neurological Surgery in any way. I understand that any misrepresentation in this application and its accompanying documents may be cause for immediate termination of my application process or future employment. I authorize UF Department of Neurosurgery to contact any or all of my former employers, educational institutions and/or other persons or organizations that may have information relevant to my application. I understand that any information obtained will be treated as confidential information. Signature: _____ Date: _____