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VITREORETINAL DISEASES & SURGERY FELLOWSHIP APPLICATION

PICTURE-(OPTIONAL)

Name: _____ Date: _____
(last, first, middle)

Current Address: _____
(Street and/or apartment number) (City) (State) (Zip)

Telephone: Home:() _____ Office:() _____ Ext: _____

Address where mail should be sent: _____

Fax number:() _____

E-mail address: _____

SECTION 1: PERSONAL INFORMATION

Social Security Number: _____ Sex: _____

Birthdate: _____ Birthplace: _____
(month, day, year)

Current Citizenship: _____
(country)

If non-U.S. citizen, date of admission to U.S.: _____

Type of visa held: _____

Military Service Rank: _____ Branch: _____ Arm of Service: _____

Dates: from _____ to _____

EDUCATIONAL/TRAINING HISTORY

(If two degrees at the same level are held, enter the more recent)

Specific Degree	Field of Study	Institution Conferring Degree	State (U.S.) Country (non-U.S.)	Year Completed
Bachelor's	_____	_____	_____	_____
Master's	_____	_____	_____	_____
M.D. or equivalent	_____	_____	_____	_____
Ph.D. or equivalent	_____	_____	_____	_____
Other	_____	_____	_____	_____

POSTDOCTORAL TRAINING

HOSPITAL	CITY	STATE	DATES (from-to)	TYPE
PGY 1	_____	_____	_____ to _____	_____
Residencies	_____	_____	_____ to _____	_____

FELLOWSHIP TRAINING

INSTITUTION	CITY	STATE	AWARD SOURCE*	DATES	SPECIALTY
Post-MD for Research or Clinical Training	_____	_____	_____	_____ to _____	_____
Post-PhD	_____	_____	_____	_____ to _____	_____
_____	_____	_____	_____	_____ to _____	_____

*Award source: (1) National Institutes of Health; (2) Other: Public Health Service; (3) All other Department of Health & Human Services, formerly D/HEW; (4) National Science Foundation; (5) Veterans Administration; (6) other Federal; (7) Foundation, society, association; (8) Industry, business; (9) all other.

PROFESSIONAL CREDENTIALS

Current Licensure: (state) _____; (year) _____; by _____ reciprocity or by _____ examination (exam) _____
Current Licensure: (state) _____; (year) _____; by _____ reciprocity or by _____ examination (exam) _____
Current Licensure: (state) _____; (year) _____; by _____ reciprocity or by _____ examination (exam) _____

Medical Specialty
Or Sub-Specialty

U.S. Board Certified
Yes _____ No _____

Year Certified

Primary: _____

Secondary: _____

Eligible for certification by the American Board of _____

A. If a graduate of a foreign medical school, have you obtained certification from the Educational Commission for Foreign Medical Graduates? _____ Indicate the exams passed: ECFMG _____; Visa Qualifying Examination (VQE) _____; Foreign Medical Graduate Exam in the Medical Sciences (FMGEMS) _____. Please enclose a copy of your exam results and a copy of your ECFMG certificate.

B. Are you licensed in the State of Texas? _____ If not, what are your plans to obtain a valid license? _____
Is there any reason to believe you may have trouble obtaining malpractice insurance in Texas? _____ No _____ Yes
If yes, please explain on a separate sheet of paper.

C. Are you aware of the requirements for obtaining a medical license in Texas? If not, please visit the Texas State Board of Medical Examiners website at www.tmb.state.tx.us for physician applicant information.

CURRICULUM VITAE

- A. Please include your CV with the following information:
- B. Please list: (a) membership in professional or honorary societies (include offices); (b) prizes, awards and those fellowships not identified above; (c) positions on national, state or local advisory bodies (include dates)
- C. Please list three persons (name and address) who know you well, and from whom you will obtain letters of recommendation:

- D. A one page personal statement describing your plans and aspirations for yourself as a vitreo-retinal surgeon.

CERTIFICATIONS

For the duration of my appointment at Retina and Vitreous of Texas, I assume the responsibility for keeping informed of the standard regulations regarding human experimentation and of abiding by those regulations.

I certify that to the best of my knowledge, the above information is accurate and I have not knowingly withheld pertinent information.

(Signature)

(Date)

Official Fellowship Match number

FOR MORE INFORMATION ON THE PROGRAM AND THE PRACTICE, VISIT WWW.RETINATEXAS.COM.