

College of Medicine - Jacksonville

PEDIATRIC INFECTIOUS DISEASES & IMMUNOLOGY  
653-1 West Eighth Street Jacksonville, Florida 32209  
(904) 244-3051



**APPLICATION FOR FELLOWSHIP TRAINING**

TYPE OR PRINT CLEARLY

DATE APPLYING FOR: \_\_\_\_\_, 20\_\_\_\_\_.

LEVEL APPLYING FOR: 4 5 6 P.G.Y.  
(Circle one)

NAME: \_\_\_\_\_  
Last First M.I.

AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_ GENDER: \_\_\_\_\_

ADDRESS:

\_\_\_\_\_  
No. Street Apt./Ste.  
\_\_\_\_\_  
City State Zip

TELEPHONE (DAY): ( ) \_\_\_\_\_ (EVENING): ( ) \_\_\_\_\_  
CELL PHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_  
E-MAIL: \_\_\_\_\_ PAGER: ( ) \_\_\_\_\_

PREMEDICAL EDUCATION:

College or University: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

MEDICAL EDUCATION:

School: \_\_\_\_\_ Degree: \_\_\_\_\_

Dates Attended: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

GRADUATE MEDICAL EDUCATION (Internships, Residencies, etc.)

Residency: \_\_\_\_\_  
(Hospital or University)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(Years Attended)

Other:

\_\_\_\_\_ (Type)

\_\_\_\_\_ (Hospital or University)

\_\_\_\_\_ (Address)

\_\_\_\_\_ (Years Attended)

HOSPITAL EXPERIENCE OR PRACTICE (Other than previously indicated):

Name	Address	Practice
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

At the time I begin the graduate medical education program for which I am now applying, I will/will not have taken the follow examinations:

I. USMLE Part III  Will have taken  Will not have taken

II. American Board of Pediatrics  Will have taken  Will not have taken

Will be eligible  Will not be eligible

SERVICE OBLIGATIONS (National Health Service Corps, Armed Forces Scholarship, State Programs, Etc.)

I am not required to fulfill any service obligations

I am committed to fulfill the following service obligation(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RESEARCH INTERESTS AND/OR PUBLICATIONS:

1. \_\_\_\_\_

2. \_\_\_\_\_

HOBBIES AND INTERESTS: \_\_\_\_\_

CITIZENSHIP:  U.S.A.  OTHER: (specify country) \_\_\_\_\_

ECFMG CERTIFICATE: No. \_\_\_\_\_ Date: \_\_\_\_\_ VISA No.: \_\_\_\_\_ Type: \_\_\_\_\_  
(if applicable) (if applicable)

REFERENCES: (Include the Director of Training Program)

Name

Address

1.

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2.

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3.

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4.

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SUPPORTING DOCUMENTS - A completed application **MUST** include:

1. A copy of medical school diploma.
2. USMLE I & USMLE II scores.
3. ECFMG Certificate (if applicable)
4. Curriculum Vitae
5. Personal Statement including career goals/plans.

PREFERRED DATES FOR INTERVIEW:

First Choice: \_\_\_\_\_

Second Choice: \_\_\_\_\_

Third Choice: \_\_\_\_\_

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Date

Signature

**MAIL COMPLETED APPLICATION & SUPPORTING DOCUMENTS TO:  
ANA M. ALVAREZ, M.D., PROGRAM DIRECTOR  
PEDIATRIC INFECTIOUS DISEASES & IMMUNOLOGY FELLOWSHIP  
UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE – JACKSONVILLE  
653-1 WEST EIGHTH STREET / LRC, 3RD FLOOR  
JACKSONVILLE, FLORIDA 32209**