

**Family Medicine Obstetrics Fellowship Application
University of Illinois College of Medicine at Peoria**

Name: _____,
Last First Middle

Present address (street)

(City) (State) (Zip)

Preferred Phone #: _____ **Pager:** _____

Alternate Phone #: _____ **E-mail:** _____

Birthplace: _____ **Citizenship:** _____

If you are **NOT** a citizen of the United States, please complete the following:

Are you are permanent U.S. resident? Yes No

What kind of visa do you hold or will you hold while you are here? _____
(A copy of your visa or green card **MUST** be enclosed with application.)

How many dependents will accompany you? _____

If you are in the U.S. on an exchange visitor program, please name your present sponsor.

Licensure: Please provide the license number, date issued and state(s) _____

Are any of your licenses limited or temporary?
No Yes If yes, please explain.

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? No Yes. If yes, please explain.

Application Requirements

In addition to this application, you are required to submit the following information:

A **Current Curriculum Vitae** that includes:

Education: List college/university, graduate and professional schools attended. Indicate dates attended, major, degree received, and date received

Academic honors, scholarships, and other awards you have received

Post Graduate Training: Indicate dates, institution, location and specialty

Fellowships Held: Indicate the name of the fellowship, institution and date

Board/Subspecialty Board Certifications: Indicate number and year

Research and Publications

Personal Statement describing your interest in this fellowship and your goals

A copy of your **USMLE transcript** (score reports are not sufficient)

A copy of your **In-Training Exam Scores Report**

Official procedure log documenting: (please total your procedures)

of Vaginal Deliveries

of C-Sections – primary and assist

If you are a graduate of a foreign medical school (except Canada), you are required to be certified by **the Educational Council for Foreign Medical Graduates**. (Please submit a copy of this certificate with this application.)

Three Letters of Recommendation including one from your residency program director or department chair (Please have these sent directly to Dr. Rahmat Na'Allah, Program Director).

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION, INCLUDING THE STATEMENT OF PURPOSE AND IN THE SUPPORTING DOCUMENTS IS COMPLETE AND ACCURATE. I UNDERSTAND THAT SUBMISSION OF INACCURATE INFORMATION MAY BE SUFFICIENT CAUSE FOR DENIAL OF ADMISSION OR TERMINATION OF ENROLLMENT.

Print name

Signature

Date

Return application with required attachments to:

Melissa Koch, Coordinator, Family Medicine Obstetrics Fellowship

UICOMP Department of Family and Community Medicine

815 Main Street, Suite C

Peoria, IL 61602

Phone (309) 672-4984 Fax (309) 672-4790