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 a permanent U.S. resident? Yes No

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**
A copy of your **COMLEX transcript if you are a DO**

Official procedure log from residency tracking software documenting:
# of Vaginal Deliveries
# of C-Sections – separate out 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.

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
Or email to Melissa.Koch@carle.com