UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE
DEPARTMENT OF OPHTHALMOLOGY

Bascom Palmer Eye Institute / Anne Bates Leach Eye Center

Clinical Fellowship Subspecialty OCULAR PATHOLOGY
(type)

Start date: June (year) End date: June (year)

Please print or type. Read carefully and complete all questions.

Personal Data

Name in full _____
FIRST MIDDLE LAST

Current mailing address _____
STREET

_____
CITY STATE ZIP

Telephone (___) _____ (___) _____ (___) _____
DAY NIGHT CELL

Email address _____

Emergency Contact _____
NAME RELATIONSHIP

_____
STREET ADDRESS CITY STATE ZIP

Telephone (___) _____ (___) _____
DAY NIGHT

Are you able to perform the duties of the Fellow position? Yes ☐ No ☐

If you are unable to perform all the duties of the Fellow position, identify modifications which would enable you to perform the duties (i.e., depth perception): _____

_____

_____

_____

Education

Please list chronologically your activities from the time of graduation from high school, beginning with undergraduate school to the present, **EVEN** if submitting a C.V. **DO NOT SKIP THIS STEP**. Include internship and residency.

From **To** **Name of School** **Location** **Degree, if any, & date**

(If additional space is required, please use separate sheet of paper)

Medical Licensure and Certification (if applicable)

Date and total score of each part of National Boards (USMLE) or FLEX Examinations **(must attach copies or have results sent)**

Medical licensures - **MUST HAVE FLORIDA LICENSE BEFORE BEGINNING CLINICAL FELLOWSHIP** (state or province and dates – attach copies) **NOT REQUIRED FOR PATHOLOGY FELLOWSHIP**

Have you ever had an application for medical licensure denied? Yes ☐ No ☐
If so, state date, circumstances and state where the license was denied. (Use separate sheet of paper if needed).

Have you ever had a medical license revoked? Yes ☐ No ☐
If so, state date, circumstances and state where the license was revoked. (Use separate sheet of paper if needed).

Have you ever been convicted of a felony? Yes ☐ No ☐
If so, state as to the court, nature of offense, disposition and date of case. (Use separate sheet of paper if needed).

Experience

Military service or commitment

Membership in professional societies

Publications_____

_____

_____

_____

Foreign Medical Graduates Only (information required for Visa processing)

You must also have an appropriate visa or status that permits you to work in the United States.

Citizenship & date_____ If not US citizen, type of Visa_____

Note funding source of breakdown of $_____

If on a J-1 exchange visitors visa, give country_____

Have you passed your **Foreign Medical Graduates Examination in the Medical Sciences** (FMGEMS) or **USMLE**?
Yes____ ____ No____ ____ **(It is necessary to submit a copy of the certificate with this application).**

Score on Basic Sciences _____Clinical Sciences_____English_____Pass/Fail (circle one)

Give number and indicate type of certificate_____Standard_____Interim_____

When did you first begin training in the United States?_____

References

At least three letters of reference are required: one from the Dean of your medical school; two from other physicians who have supervised your recent activities. List below the names of all your references and ask them to write directly to: Bascom Palmer Eye Institute, Attn: Kathy Corser, Clinical Fellowship Program, P.O. Box 016880, Miami, FL 33101 (street address 900 NW 17 Street, Miami, FL 33136). These can be emailed as well: kcorser@med.miami.edu

1._____
Name Address Phone Number

2._____
Name Address Phone Number

3._____
Name Address Phone Number

Any others:

_____
Name Address Phone Number

_____
Name Address Phone Number

Enclose with this application or forward separately

1. Brief personal/autobiographical statement
2. Medical School transcript
3. College transcript
4. USMLE transcripts
4. Dean's letter from medical school
5. At least Two (2) letters of reference
6. Curriculum Vitae

AGREEMENT

If offered an appointment as a Clinical Fellow/Student at the Bascom Palmer Eye Institute, University of Miami Leonard M. Miller School of Medicine and I accept same, I will abide by all the Rules and Regulations of the included Hospitals for members of the House Staff and will to the best of my ability fulfill the obligations of my assignment for the full term of my appointment.

Signature of Applicant_____Date_____

Fellowship Match # (if applicable) _____

CHECK TO SEE THAT ALL QUESTIONS HAVE BEEN ANSWERED

Mail application and enclosures to:
Isabel R. Perez
Bascom Palmer Eye Institute
P.O. Box 016880
Miami, Florida 33101
(street address: 900 NW 17 Street, Miami, FL 33136) 305/326-6391; fax 305/326-6580
irperez@med.miami.edu

Bascom Palmer Eye Institute
UNIVERSITY OF MIAMI HEALTH SYSTEM

www.bascompalmer.org