ATTACHED RECENT PHOTO HERE

Wake Forest Baptist Health
Wake Forest School of Medicine
Medical Center Boulevard
Winston-Salem, North Carolina 27157

Multiple Sclerosis Fellowship Application

PROPOSED BEGINNING DATE OF TRAINING: _____

FULL NAME _____
(Last) (First) (Middle)

ADDRESS _____
(Street) (City-State) (Zip)

EMAIL ADDRESS

TELEPHONE _____ _____
(Days) (Nights & Weekends)

SOCIAL SECURITY #

PLACE OF BIRTH _____ DATE OF BIRTH

☐ US CITIZEN ☐ EAD/GREEN CARD ☐ J-1 VISA EXPIRATION: ☐

MARITAL STATUS _____ SPOUSE'S NAME _____

EMERGENCY CONTACT NAME AND NUMBER _____

If applicable, please include a copy of your ECFMG certificate with this application.

ECFMG Certificate:	No	ECFMG No.:		Issued Date:		Expiration Date:	

Enter your scores in the appropriate boxes below.

USMLE Step 1:		USMLE Step 2 CK:		USMLE Step 2 CS:		USMLE Step 3:	
COMLEX Level 1:		COMLEX Level 2 CE:		COMLEX Level 2 PE:		COMLEX Level 3:	

ACHIEVEMENTS (Awards, Honorary Societies, etc.)

POST GRADUATE EXPERIENCE

	Institution	Degree	From MM/DD/YYYY	From MM/DD/YYYY
Internship:				
Residency:				
Fellowship:				

MEDICAL SCHOOL

Institution	Degree	From MM/DD/YYYY	From MM/DD/YYYY

GRADUATE AND UNDERGRADUATE SCHOOLS

Institution	Degree	From MM/DD/YYYY	From MM/DD/YYYY

DO YOU HAVE A FULL LICENSE TO PRACTICE MEDICINE? Yes _____ No ☐

If yes, give state(s) _____

FUTURE PLANS:
Teaching ☐ Private Practice ☐ Generalist ☐ Specialist ☐ Research ☐

FURTHER COMMENTS:

Three (3) letters of recommendation are required. One (1) must be from your current, or most recent, Program Director of your residency program and two (2) from faculty that you have worked with during the past 12 months. List their names, title, and email address below:

NAME	TITLE	EMAIL ADDRESS
	Program Director	

PLEASE RETURN TO: April Edwards, Fellowship Coordinator, Department of Neurology
Wake Forest School of Medicine
Medical Center Blvd, Winston-Salem, NC 27157
Phone: (336) 716-7548 E-Mail: apedward@wakehealth.edu

PRINT

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