

**APPLICATION FOR POSTDOCTORAL FELLOWSHIPS IN  
CLINICAL NEUROPHYSIOLOGY & EPILEPSY**

**PLEASE PRINT OR TYPE**

<b>NAME</b> (Last)	(First)	(Middle)	<b>SOCIAL SECURITY NUMBER</b>
<b>CURRENT ADDRESS</b> (Street)	(City & State)	(Apartment)	(Zip Code)
<b>PERMANENT ADDRESS</b>			
<b>CURRENT PHONE #</b>		<b>PERMANENT PHONE #</b>	
<b>DATE OF BIRTH</b>		<b>SEX</b>	

**Please check the box below:**

- Adult  
 Pediatric

**Please check whether you interested in a one-year or two-year fellowship:**

- One year  
 Two year

**If you are only interested in a one-year fellowship, please check which you would prefer:**

- Clinical Neurophysiology/EEG  
 Clinical Neurophysiology/EMG  
 Epilepsy

**GENERAL INFORMATION**

Are you a citizen of the United States? Yes No

If answer is "No" give:

Type of Visa \_\_\_\_\_

Alien Registration # \_\_\_\_\_

Do you have the legal rights to work in the United States? **H1B visa holders are not eligible.** Yes No

Do you have any physical, emotional, or mental disability that would prevent you from performing your duties if you are appointed? If yes, please give details on a separate sheet. Yes No

**EDUCATION**

	INSTITUTION	ADDRESS	DATES OF ATTENDANCE	DEGREE OR DIPLOMA
<b>COLLEGE</b>				
<b>MEDICAL SCHOOL</b>				
<b>OTHER EDUCATION</b>				

If graduate of foreign medical school, give:  
ECFMG Number \_\_\_\_\_

Date \_\_\_\_\_

**HOSPITAL EXPERIENCE/TRAINING IN SPECIALTY  
(GIVE MOST RECENT EXPERIENCE FIRST)**

INSTITUTION	COMPLETE ADDRESS	POSITION HELD	INCLUSIVE DATES

**AWARDS, HONORS, RESEARCH, SCIENTIFIC INVESTIGATION, PUBLICATION  
(PLEASE ATTACH A CURRICULUM VITAE)**

**CREDENTIALS**

Diplomate of National Board of Medical/Dental Examiners? Yes No Flex Examination? Yes No

Are you licensed to practice medicine/dentistry in any State? Yes No

If "Yes", list State(s) and license number.

State \_\_\_\_\_ License # \_\_\_\_\_ Date of Expiration \_\_\_\_\_

Do you have a Drug Enforcement Agency (DEA) Number? Yes No  
If "Yes" give number \_\_\_\_\_ Date of Expiration \_\_\_\_\_  
NRMP/Match Number (if known) \_\_\_\_\_

**REFERENCES**

Please request three letters of reference, from teachers in medicine or physicians under whom you have worked. Letters of reference should be addressed to the following respective program director:

- Christopher Elder, MD. Program Director for Clinical Neurophysiology (EEG Track)
- Christina Ulane, MD. Program Director for Clinical Neurophysiology (EMG Track)
- Daniel Lowenstein, M.D. Program Director for Epilepsy

All application materials must be sent to Ashley Chang, Fellowship Coordinator, via e-mail: [adc2193@cumc.columbia.edu](mailto:adc2193@cumc.columbia.edu)

List the names and addresses of the physicians who will write letters on your behalf.

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_