FELLOWSHIP APPLICATION
ADULT & PEDIATRIC CNS

Department of Radiation Oncology
The Ohio State University James Cancer Hospital

Place 2x2 passport photo here (sending by mail)

OR

Attach digital photo to application (submitting electronically)

We require the following information to be submitted with your application:

- Completed Fellowship Program Application (*this form*)
- Current CV
- Personal statement
- Passport Photo OR Digital Photo
- 3 recent Letters of Recommendation
- Transcript of Medical School Grades (*copy will suffice*)
- USMLE scores – Step 1-3
- ECFMG Certification (i*f applicable*)

Directions – *Please type answers*

Identification Information

Name _____

I can BEST be reached at Phone _____ Email _____

Permanent Address _____
Street City, State, Zip Country (if not USA)

Mailing Address _____
Street City, State, Zip Country (if not USA)

Date of Birth _____ Place of Birth _____

Are you a citizen of the United States? Please check one ☐ Yes ☐ No*

*If you answered NO to the above, please provide your immigration status. Please check one

- ☐ Permanent
- ☐ J-1 Exchange visitor
- ☐ H-1 Temporary Student/Trainee
- ☐ Other _____

Are you certified in Radiation Oncology in your home country? Please check one ☐ Yes ☐ No

ECFMG Certificate Number _____ Expiration Date _____ Please check one Interim Permanent

Fellowship Information

Application Year Start Date: July _____ to June _____ *Please contact Education Manager for off-cycle dates*
Year Year

Areas of Special Interest, if any: _____

Education Information

Undergraduate Education

Name of Institution _____ Graduation Date _____

Address _____ Degree _____

Medical Education

Name of Institution _____ Graduation Date _____

Address _____ Degree _____

National Board Scores

USMLE Part I _____ Part II _____ Part III _____
COMLEX Part I _____ Part II _____ Part III _____

Internship Training

Name of Institution _____ Dates of Service _____ to _____

Address _____

Residency Training

Name of Institution _____ Dates of Service _____ to _____
Address _____

ABR Radiation Oncology Board

Examinations	*Date(s) Taken*	*Results (Pass/Fail)*
Core	_____	_____
Certification	_____	_____
Other	_____	_____

Other postgraduate training _____

Membership in organization, professional, and other_____

Are you a member of Alpha Omega Alpha (AOA)?Please check one ☐ Yes ☐ No

Are you a member of Golden Humanism Honor Society (GHHS)? Please check one ☐ Yes ☐ No

Are you eligible for VA benefits? Please check one ☐ Yes Branch of Service _____ ☐ No

Experience (practical or hospital)

_____

References--From persons acquainted with your educational and professional work within the last 3 years.
Please include the Program Director of your residency, current, or last educational program (name, address, and position).

1._____

2._____

3._____

Have you ever been suspended, expelled, or resigned from any medical school or hospital appointment?
Please check one ◯ Yes* ◯ No
*If yes, explain _____

_____

Have you ever been convicted of a misdemeanor? Please check one ◯ Yes* ◯ No

*If yes, explain _____

_____

Have you ever been convicted of a felony? Please check one ◯ Yes* ◯ No

*If yes, explain _____

_____

Is there anything in your past history that would limit your availability to be licensed or would limit your ability to receive hospital privileges? Please check one ◯ Yes* ◯ No

*If yes, explain _____

_____

Are you licensed to practice medicine in Ohio? Please check one ◯ Yes ◯ No

Extracurricular medical experience not covered by the above questions

Scientific papers which have been published

APPLICANT'S NOTICE*-- Appointments can be made for one year only, subject to continuing advancement as opportunity and appearance permit, but this information is not obligated to extend any appointment beyond one year. Appointments are made for a specific service. No departmental chairperson can guarantee an appointment on service outside of his/her own department, but such interchange may be accomplished if and when it is mutually advantageous to all concerned. The application is made with the understanding that if I am appointed I will serve for the full time for which I am appointed, and I will faithfully observe the rules and regulations of The Ohio State University.*

Signature _____ Date _____

Electronic/digital signature accepted

Please send all required documentation to:

Meg Decker
Education Program Manager
The James Cancer Hospital
Department of Radiation Oncology
460 West 10th Avenue, Suite D258
Columbus, OH 43210
Phone: 614-293-3255 Fax: 614-366-2774
Email: megan.decker@osumc.edu