Thank you for choosing OhioHealth to be a part of your educational experience.

APPLICATION PROCESS

The OhioHealth Diabetes Fellowship is open to graduates of ACGME- or AOA- accredited Family Medicine or Internal Medicine residency programs. Applicants must be available and ready to begin fellowship on August 1.

Directions: Please be sure to thoroughly read and complete every section of this application. The application will not be considered complete until all of the additional items listed in **Section C** of this application have been received. The completed application should be submitted via email to the O'Bleness Hospital Graduate Medical Education Department, at **OBH-MedicalEducation@ohiohealth.com**.

Application deadline is February 1.

You will be notified on the status of your application within two weeks of submission of all requested documents. Applicants must be available to interview in person if so requested.

Please allow 10 business days before contacting the program for a response.

SECTION A: Applicant Information

Name: _____ **Date of application:** ___/___/____
Last First MI

Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: (_____) _____ **E-Mail Address:** _____

DOB: ____/_____/_____ **Gender:** ❑ male ❑ female ❑ other/prefer not to state

Education and Experience

❑ Residency training:

Full Program Name (include specialty): _____

Program Director Name: _____

Dates of Training: ____/____/_____ to ____/____/_____ ❑ AOA ❑ ACGME

Full Program Name (include specialty): _____

Program Director Name: _____

Dates of Training: ____/____/_____ to ____/____/_____ ❑ AOA ❑ ACGME

❑ I have rotated in an OhioHealth hospital.

Locations and dates of previous OhioHealth rotations: _____

❑ I am currently in practice (please list past 10 years, attach additional if necessary):

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Dates of employment: ____/____/_____ to ____/____/_____

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Dates of employment: ____/____/_____ to ____/____/_____

❑ I have medical staff privileges at an OhioHealth hospital.

- ❑ Doctors Hospital
- ❑ Dublin Methodist
- ❑ Grant Medical Center
- ❑ O'Bleness Hospital
- ❑ Riverside Methodist
- ❑ Other: _____

❑ I am a clinical instructor at Ohio University.

Licensure

State Medical Licensure

❑ I hold a medical license in the state of Ohio.

License Number: _____ Dates Valid: _____

❑ I hold a medical license in another state.

State: _____ License Number: _____ Dates Valid:_____

❑ I hold a current training certificate/training license.

State: _____ License Number: _____ Dates Valid:_____

Have you ever been convicted of a misdemeanor? ❑ yes ❑ no
Have you ever been convicted of a felony or misappropriation of funds? ❑ yes ❑ no

Describe if yes: _____

Are there any actions or proceedings which have involved the suspension or revocation of your license or training permit in any state or jurisdiction? ❑ yes ❑ no

Describe if yes: _____

SECTION B: Graduates of Medical Schools Outside the United States

OhioHealth considers applicants without regard to race, color, religion, gender, national origin, marital or veteran status, disability, or any other legally protected status.

OhioHealth O'Bleness Hospital Diabetes Fellowship will consider applicants who are U.S. citizens, lawful permanent residents, asylees and refugees, and other individuals with work authorizations that do not require visa sponsorship by O'Bleness Hospital.

ECFMG Certificate Number: _____ Date Issued:_____

Work Authorization Number (if non US citizen):_____ Date Issued:_____

SECTION C: Required Additional Items

The items listed below must be received by O'Bleness Graduate Medical Education prior to application review.

- ❑ Current CV
- ❑ Personal Statement describing your interest in this fellowship
- ❑ Notarized copy of your residency training completion certificate, if training is already complete
- ❑ A color photograph (digital or .jpeg)
- ❑ 2 letters of recommendation, at least one of which must be from your residency training Program Director or your current employer

Please have your references mail letters of recommendation to:
O'Bleness Graduate Medical Education
55 Hospital Drive
Athens, Ohio 45701
Or by email to:
OBH-MedicalEducation@ohiohealth.com

SECTION D: Acknowledgement

Authorization and Release: To the best of my knowledge, the information that I have provided in this application is true and free of any consequential omissions. I authorize OhioHealth O'Bleness Hospital Graduate Medical Education to verify any of the information I have provided, and further authorize any of the schools, institutions, or persons listed to provide any information about me contained in their records. If I am accepted for any position by OhioHealth O'Bleness Hospital, I agree to abide by the policies, rules, regulations and practices of OhioHealth O'Bleness Hospital.

Signature: _____ **Date:** _____

Printed Name: _____