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

APPLICATION PROCESS

The OhioHealth Multiple Sclerosis/Neuroimmunology Fellowship is open to graduates of ACGME- or AOA-accredited Neurology residency programs.

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 OhioHealth Graduate Medical Education Department, at **rmhmeded@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

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

OhioHealth Multiple Sclerosis 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****.

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 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
- ❑ 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:

Riverside Medical Education, Multiple Sclerosis and Neuroimmunology
3535 Olentangy River Road
Columbus, Ohio 43214

Or by email to:

rmhmeded@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 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 Hospital, I agree to abide by the policies, rules, regulations and practices of OhioHealth Hospital.

Signature: ______________________________ **Date:** ______________

Printed Name: ____