ASSOCIATED RETINAL CONSULTANTS, P.C.
APPLICATION FOR VITREORETINAL FELLOWSHIP

NAME IN FULL ______________________________
Last First Middle

Home Address ______________________________
Number Street City State Zip Code Phone Number

Mailing Address (If different from home address):

____
Number Street City State Zip Code Phone Number

______________________________ E-mail address: ______________________________

This Fellowship is to begin training July 7, 20________

Photograph Optional

Are you a citizen of the United States ☐ YES ☐ NO

If you are permitted to study/work in the United States pursuant to a visa, please state:

Type Visa______________Date first obtained______________Expiration date______________

Do you have any impairments (physical, mental or medical), which require accommodation in order for you to complete your postgraduate training program successfully?

☐ YES ☐ NO

RESULTS OF US. MEDICAL LICENSURE EXAM:

STEP 1 ______________________________
Total Score Date

STEP 2 ______________________________
Total Score Date

STEP 3 ______________________________
Total Score Date

LICENSURE INFORMATION ______________________________
Number Date Conferred State Temporary or permanent

Have you ever been denied a license to practice medicine, or had your license restricted in any way? ☐ YES ☐ NO
(If yes, attach a written explanation)

If you have taken an examination other than the USMILE (e.g. NBME, FLEX, or ECFMG), attach date(s), and certificate(s).

Have you signed an agreement with the NATIONAL FELLOWSHIP MATCHING PROGRAM? ☐ YES ☐ NO

If so, what is your number? ______________________________

PREMEDICAL EDUCATION

College or University	Location	Dates (from-to)	Degree	Class Standing

MEDICAL EDUCATION (List all medical schools attended, and, for any from which you did not graduate, state the reason for leaving.)

Medical School	Location	Dates (from-to)	Degree	Class Standing

POSTGRADUATE TRAINING (List all postgraduate training.)
First Postgraduate Year:

Institution	Location	Dates (from-to)	Type of Program

Residencies and/or Fellowships

1) ______
Institution | Location | Dates (from-to) | Type of Program

2) ______
Institution | Location | Dates (from-to) | Type of Program

3) ______
Institution | Location | Dates (from-to) | Type of Program

4) ______
Institution | Location | Dates (from-to) | Type of Program

OTHER MEDICAL EXPERIENCE (Research, practice, etc. Give type, place and dates)

PLEASE ATTACH CURRICULUM VITAE

PUBLICATIONS AND RESEARCH CONDUCTED (Give Title, periodical, pages, dates, etc.)

REQUIREMENTS FOR APPLICATION:

1. One letter should be sent by your current Program Director, three additional letters of reference should be sent by supervisory staff or faculty members with whom you have worked closely. (preferably retina faculty)
2. Personal statement, stating why you wish to pursue fellowship training in vitreoretinal disease and your long-term career plans.
3. A copy of your National Board scores.
4. Written verification of any postgraduate clinical training obtained in U.S. hospitals.
5. Medical school transcripts

Please return this application with the above material and any other inquires or replies to:

Antonio Capone, Jr., M.D., ATTN: Carol Masters
Beaumont Eye Institute
3535 W. 13 Mile Road, #555
Royal Oak, Michigan 48073

By my signature below, I attest that the information provided is complete and accurate.

Signature ______________________________ Date ______________