

**PERSONAL INFORMATION**

Fellowship Start Date: July 1, \_\_\_\_\_

**Name and Contact:**

\_\_\_\_\_  
(Last) (First) (Middle)

Have you ever changed your name through marriage, naturalization or action of a court or have you been known by any other name(s)? NO YES If yes; list original name(s) – Add additional page, if needed

\_\_\_\_\_  
(Last) (First) (Middle)

\_\_\_\_\_  
(Mailing Street Address or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

\_\_\_\_\_  
(Permanent Street Address or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(Preferred: Area Code/Phone Number) (Alternate: Area Code/Phone Number)

Email Address: \_\_\_\_\_

**Demographics:**

**Race:** American Indian or Alaskan Native  
Asian  
Black or African American  
Native Hawaiian or other Pacific Islander  
White

**Ethnicity:** No – Not Hispanic or Latino  
Yes - Hispanic or Latino

**Gender:** Male  
Female

**ECFMG Certified:** Yes No If yes, date certified: \_\_\_\_\_

**Licensing Examination:** Step/Part I Step/Part II-CK/CE Step/Part II CS/PE Step/Part III

Date: \_\_\_\_\_

Score: \_\_\_\_\_

**UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE - JACKSONVILLE**  
**DEPARTMENT OF NEUROSURGERY**  
**COMPLEX AND MINIMALLY INVASIVE SPINE SURGERY FELLOWSHIP APPLICATION**

Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received

Postgraduate Training: In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present (Internship/Residency/Fellowship).

Program Name and Full Mailing Address	Specialty Area	From: mm/yy	To: mm/yy	Did you receive credit?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Attach additional information on a separate sheet, if needed.

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SUPPORTING DOCUMENTS	APPLICANT ATTESTATION
<p>Attach the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Photo</li> <li><input type="checkbox"/> CV/Resume</li> <li><input type="checkbox"/> Two (2) Letters of Reference</li> <li><input type="checkbox"/> Personal Statement</li> <li><input type="checkbox"/> ECFMG Certificate, if applicable</li> <li><input type="checkbox"/> Licensing Exam Score Report(s)</li> <li><input type="checkbox"/> Surgical Logbook of Procedures (Surgical logbook is not required for individuals who completed residency training in the United States or Canadian.)</li> </ul> <p>I understand that my file will not be reviewed until <b>all of the above</b> documents are received.</p>	<p>I certify that the information in this application is true and complete and that I have not withheld information that might affect my qualifications for the complex and minimally invasive spine surgery fellowship in the department of Neurosurgery.</p> <p>I understand that any misrepresentation in this application and its attached documents may be cause for immediate termination of my application process or future employment.</p> <p>I authorize personnel in the College of Medicine-Jacksonville Department of Neurosurgery to contact any or all of my former employers, educational institutions and/or other persons or organizations that may have information relevant to my application.</p> <p>I understand that any information obtained from those contacts will be treated as confidential information.</p> <p>Signature: _____</p> <p>Date: _____</p>