



STANFORD

SCHOOL OF MEDICINE

STANFORD UNIVERSITY SOM APPLICATION

CLINICAL MULTIPLE SCLEROSIS AND NEUROIMMUNOLOGY FELLOWSHIP

Applying for the year to start: 2014____ 2015____

Name:	E-mail Address:
Mailing Address:	Home Telephone: ()
Work Telephone: () 	Date of Birth:
Place of Birth:	Gender:
Name, Address & Telephone number of next of kin or other person for permanent contact:	

NON-MEDICAL DEGREES:

COLLEGE / GRADUATE SCHOOL	DEGREE	DATE GRADUATED

MEDICAL DEGREES:

MEDICAL SCHOOL	DEGREE	DATE GRADUATED

National and State Board Examinations (Please give date/numerical score):

Part I	Part II
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California laws require that all residents and fellows hold a state license. Those who **DO NOT HAVE** such a license must take and pass the next examination following commencement of service, or obtain licensure by reciprocity with National Boards or another state.

Medical Licensure (License Number and State):
Internship/Location and Specialty:
Residency/Location and Specialty:
Fellowship/Location and Specialty:
Membership in Scientific and Professional Organizations:

If you have ever left any course of residency, internship or fellowship for any reason other than the expiration of the usual term, please state the reason(s):

Research in Progress:

Papers Written:

Present State of Health:

Do you have any physical or mental health impairments?

Signature: _____ *Date:* _____

Stanford University Medical Center is committed to increasing representation of women and members of minority groups in its residency and fellowship training programs and particularly encourages applications from such individuals. You may indicate your ethnic origin below, however, self-identification by race is entirely voluntary.

Black		Puerto Rican (Mainland)	
American Indian or Alaskan Native		Puerto Rican (Commonwealth)	
White*		Other Hispanic	
Asian or Pacific Islander			
Mexican American or Chicano			

*** Having origins in any of the original people of Europe, North Africa or the Middle East**