UNIVERSITY OF CALIFORNIA SAN DIEGO, SCHOOL OF MEDICINE
SAN DIEGO, CALIFORNIA 92037

Application for Advanced Heart Failure Fellowship Training Program 2019-2020

Please type in and return completed application via mail or email (preferred) to:
Eric Adler, MD
Medical Director of Heart Transplant & Circulatory Support
Program Director, Advanced Heart Failure Fellowship Program
University of California, San Diego
9500 Gilman Drive, MC 7411
La Jolla, CA 92037-7411
c/o mrelaford@ucsd.edu

Name______________________________________ **Please include photo/headshot with application**
Last, First Middle

Permanent Mailing Address: ____

Present Mailing Address: ____

Telephone Numbers: Home____________________ Hospital___________________________

Email address: _________________________________

Licensed to practice Medicine in State of: _________________ License #: ______________________

Passed USMLE Part I ____ yes ____ no Part II ____ yes ____ no Part III ____ yes ____ no

If you are a Foreign Medical Graduate, have you passed the:

ECFMG ____ yes ____ no Certificate Date____________ Certificate Number_____________

Are you on a Visa? Yes ___ No ___ If yes, what type and when does it expire? ____________________________

Proof of U.S. citizenship or eligibility for U.S. employment will be required upon hire in accordance with regulation established pursuant to the Immigration Reform and Control Act of 1986.

Is funding from an outside source available? Yes ___ No ___ Source and amount of grant: ___________________

EDUCATION

Premedical/preosteopathic: ______________________________ Dates____________ Degree__________

Other: ____ Dates____________ Degree__________

Medical/Osteopathic: _________________________________ Dates____________ Degree__________

Internship: ____ Dates____________ Degree__________
Hospital Chief of Service

Residencies:

____ Dates____________ Degree__________
Hospital Chief of Service

____ Dates____________ Degree__________
Hospital Chief of Service

Fellowships:

____ Dates____________ Degree__________
Hospital Chief of Service

____ Dates____________ Degree__________
Hospital Chief of Service

Language skills other than English (list languages and place an X in the appropriate area)

Language: ___________________________

	Excellent	Good	Fair
Read	____	____	____
Speak	____	____	____
Understand	____	____	____

Language: ___________________________

	Excellent	Good	Fair
Read	____	____	____
Speak	____	____	____
Understand	____	____	____

RACE/ ETHNICITY (optional)

___ American Indian or Alaska Native
___ Asian or Pacific Islander
___ Black or African American
___ Hispanic or Latino
___ White
___ Other
___ Decline to declare

PREVIOUS EMPLOYMENT (Professional and/or Scientific)

Place: ______________________________ Dates____________ Duties____________

Place: ______________________________ Dates____________ Duties____________

Scholastic Societies: ____

Honors and Awards: ____

Previous Research and Scientific Investigations (complete here or attach CV):

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Peer Reviewed Publications (complete here or attach CV):

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Describe Career goals or professional plans for the future. Why have you chosen a career in Advanced Heart Failure? What are your clinical and research objectives? What are your plans after completion of fellowship training? USE THIS SPACE OR ATTACH A SEPARATE LETTER.

REFERENCES:

Provide (3) three letters of reference:

1. ____
Name | Title | Institution

2. ____
Name | Title | Institution

3. ____
Name | Title | Institution

PRIVACY NOTIFICATION STATEMENT

The information collected is used to satisfy the educational mission of the University and its legal obligations, including determination of eligibility, assessment and evaluation of professional qualifications.

With the exception of the Affirmative Action data, all information requested is mandatory. If the information is not provided, the application will be deemed incomplete and not considered by the Program. The information you provide will be reviewed by the Departmental Residency selection committee and may be released pursuant to applicable Federal or State law. The privacy of your file will be the responsibility of the Department.

Individuals have the right to review their own record in accordance with the Information Practices Act and University policy. Information on these policies may be obtained from the training Program to which you have applied and where your file is maintained.

I hereby authorize representatives of the School of Medicine to contact any or all of my former employers, educational institutions attended, or other persons or organizations determined to have information relevant to my application for clinical training. I further consent to such persons and organizations releasing relevant information to the School of medicine, notwithstanding that it might otherwise be confidential. I understand that any information obtained by the School of Medicine will be treated as confidential personal information. I hereby certify that I have read and understood all statements and questions on this application and that my responses are true and complete to the best of my knowledge. If employed, I understand that falsification of this record may be considered cause for my termination.

____ ______________________

Signature of Applicant **Date**