



# The University of Connecticut School of Medicine

## ~ Fellowship Training Program Application ~



Year Assignment Desired

Specify which specialty you are interested in:

- Pediatric Endocrinology  
  Pediatric Pulmonary  
  Pediatric Emergency Medicine  
  Medical Genetics

Name (last name, first name - type or print clearly)	Country of Citizenship	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Mailing Address - Street	Date of Birth	Place of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>

Mailing Address - City/State/Zip	Telephone	Type of Visa (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email Address	Sex	Military Status (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>

**EDUCATION:**

Colleges, Universities, and Medical Schools	Years (from-to)	Degree
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Internships, Residencies, Fellowships** (indicate type)

Hospital	Type of Service	Years (from-to)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Honors, Awards and Publications** (use separate sheet if necessary)

<input type="text"/>
<input type="text"/>
<input type="text"/>

- Residency Training Track:**  
  Emergency Medicine  
  Pediatrics  
  Internal Medicine  
 (U.S. residency required for Genetics applicants)  
  OB/GYN  
  Family Medicine

**USMLE/COMLEX Scores** (Attach copies of score sheets.)

Step 1 - <input type="text"/>	Step 2 CK/CS- <input type="text"/>	Step 3 - <input type="text"/>
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**ECFMG Certificate Number** (if applicable) Please include copy of certificate.

**Academic, Professional or Committee Memberships** (Use separate sheet if necessary)


**Research Interests**


**References** (List 3: Name, Title, Address)      Have you asked them to write to us?     Yes     No


**License to Practice in State of**      **Registration/License Number**      **Date First Licensed**

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**National Board Examination**      **Date of Exam**

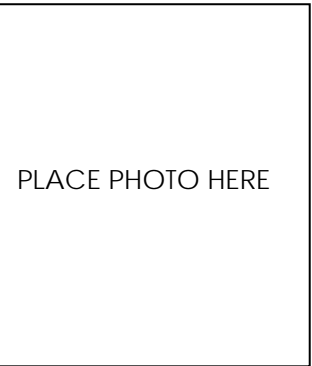
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**NRMP Number** (if applicable)      **ERAS Reg. Number** (if applicable)

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Please forward application and all correspondence to:

**Veronica A. Tomlinson**  
**Fellowship Program Coordinator**  
**Connecticut Children's Medical Center**  
**282 Washington Street**  
**Hartford, CT 06106**  
Phone: 860-545-9658  
Fax: 860-545-8627  
Email: vtomlin@ccmckids.org



A complete application should include:

- Your photo
- Curriculum Vitae
- Copies of USMLE/COMLEX scores
- Medical school transcript
- Copy of ECFMG certificate (Foreign Medical Graduates)
- Personal statement (Include professional goals and reasons for desiring a fellowship)
- Three letters of reference (they may arrive after application is submitted)

Signature of Applicant

Date Signed

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