

**THE UNIVERSITY OF CHICAGO/OPHTHALMOLOGY  
GRADUATE MEDICAL EDUCATION  
APPLICATION FOR RETINA FELLOWSHIP TRAINING**

**INSTRUCTIONS:** Please type (preferred) or print. Do not use pencil. Complete all sections of application fully.

Application to begin training on \_\_\_\_\_ Specialty Dept \_\_\_\_\_  
Month Day Year

Postgraduate Year Training Requested: PGY I \_\_\_\_\_ PGY II \_\_\_\_\_ PGY III \_\_\_\_\_ PGY IV \_\_\_\_\_ PGY V \_\_\_\_\_ PGY VI \_\_\_\_\_ PGY VII \_\_\_\_\_

Please circle one: M.D. D.O. D.D.S. Social Security Number \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Are you registered with the OMP? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ OMP Applicant Code \_\_\_\_\_

**Present home address and telephone number**

Number & Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country (if not U.S.) \_\_\_\_\_ Telephone # \_\_\_\_\_

**Address and telephone number where you can be reached during the day**

Number & Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country (if not U.S.) \_\_\_\_\_ Telephone # \_\_\_\_\_

**Previous Education**

Name of Preparatory or High School \_\_\_\_\_ Location \_\_\_\_\_ Month/Year to Month/Year \_\_\_\_\_ Degree \_\_\_\_\_

Name of College or University \_\_\_\_\_ Location \_\_\_\_\_ Month/Year to Month/Year \_\_\_\_\_ Degree \_\_\_\_\_

Name of Medical/Osteopathic or Dental School \_\_\_\_\_ Location \_\_\_\_\_ Month/Year to Month/Year \_\_\_\_\_ Degree \_\_\_\_\_

**Previous Postgraduate Training**

	Name of Institution	Location	Training Supervisor	Specialty	Dates	
					From	To
Resident						
Resident						
Resident or Fellow						
Resident or Fellow						

**Non-U.S. Citizens MUST Complete This Section**

Type of visa you have or intend to have for entrance into the U.S. \_\_\_\_\_ Exchange Visitor (J-1)  
 \_\_\_\_\_ Permanent Visa Number \_\_\_\_\_

**List those writing letters of recommendation:**

Name	Address	Position
Name	Address	Position
Name	Address	Position
Name	Address	Position

Results of National Board Examinations or U.S.M.L.E. Part I Raw Score: \_\_\_\_\_ Part II Raw Score: \_\_\_\_\_ Part III Raw Score: \_\_\_\_\_  
 Percentile: \_\_\_\_\_ Percentile: \_\_\_\_\_ Percentile: \_\_\_\_\_

Results of Flex Examination (if taken) Score: \_\_\_\_\_

**Licensure information (full license or temporary license)**

Type of License (Perm or Temp)	State	Number	Date Conferred	Expiration Date

**Professional experience, including current status, other than training (omit any employment while a full-time student)**

From	To	Employer	Position Held

**Publications, memberships in honorary scientific and professional societies, etc.**

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**Briefly describe your career objectives:**

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**International Medical Graduates-Examinations**

VQE Passed: \_\_\_\_\_ Failed: \_\_\_\_\_ Date Taken: \_\_\_\_\_

ECFMG Score: \_\_\_\_\_ Date Taken: \_\_\_\_\_

FMGEMS Basic Science Score: \_\_\_\_\_ Date Taken: \_\_\_\_\_  
 Clinical Science Score: \_\_\_\_\_ Date Taken: \_\_\_\_\_

USMLE Part I Raw Score: \_\_\_\_\_ Percentile: \_\_\_\_\_ Date Taken: \_\_\_\_\_  
 Part II Raw Score: \_\_\_\_\_ Percentile: \_\_\_\_\_ Date Taken: \_\_\_\_\_  
 Part III Raw Score: \_\_\_\_\_ Percentile: \_\_\_\_\_ Date Taken: \_\_\_\_\_

ECFMG Certificate Number: \_\_\_\_\_ Date Conferred: \_\_\_\_\_

**I certify that all statements on this application are true and accurate to the best of my knowledge.**

Date \_\_\_\_\_ Signature \_\_\_\_\_