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Wake Forest Baptist Health
Wake Forest School of Medicine
Medical Center Boulevard
Winston-Salem, North Carolina 27157

Neurocritical Care Fellowship Application

PROPOSED BEGINNING DATE OF TRAINING: ______________________

FULL NAME ______________________
(Last) (First) (Middle)

ADDRESS ______________________
(Street) (City-State) (Zip)

EMAIL ADDRESS ______________________

TELEPHONE ______________ ______________
(Days) (Nights & Weekends)

SOCIAL SECURITY # ______________ DATE OF BIRTH ______________

PLACE OF BIRTH ______________

US CITIZEN ☐ EAD/GREEN CARD ☐ J-1 VISA ☐ EXPIRATION: ☐

If applicable, please include a copy of your ECFMG certificate with this application.

ECFMG Certificate:	(Yes/No)	ECFMG No.:		Issued Date:		Expiration:	

USMLE Step 1:		USMLE Step 2 CK:		USMLE Step 2 CS:		USMLE Step 3:	
COMLEX Level 1:		COMLEX Level 2 CE:		COMLEX Level 2 PE:		COMLEX Level 3:	

ACHIEVEMENTS (Awards, Honorary Societies, etc.)

POST GRADUATE EXPERIENCE

	Institution	Degree	From MM/DD/YYYY	From MM/DD/YYYY
Internship:				
Residency:				
Fellowship:				

MEDICAL SCHOOL

Institution	Degree	From MM/DD/YYYY	From MM/DD/YYYY

GRADUATE AND UNDERGRADUATE SCHOOLS

Institution	Degree	From MM/DD/YYYY	From MM/DD/YYYY

DO YOU HAVE A FULL LICENSE TO PRACTICE MEDICINE? Yes ________ No ________

If yes, give state(s) ____

FUTURE PLANS:
Teaching ☐ Private Practice ☐ Generalist ☐ Specialist ☐ Research ☐

FURTHER COMMENTS:

Three (3) letters of recommendation are required. One (1) must be from your current, or most recent, Program Director of your residency program and two (2) from faculty that you have worked with during the past 12 months. List their names, title, and email address below:

NAME	TITLE	EMAIL ADDRESS
	Program Director	

PLEASE RETURN TO: April Edwards, Fellowship Coordinator, Department of Neurology
Wake Forest School of Medicine
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Phone: (336) 716-7548 E-Mail: apedward@wakehealth.edu