Virginia Mason Franciscan Health

Center for Digestive Health

PANCREAS RESEARCH FELLOWSHIP APPLICATION

Applications are accepted until November 30th
for the academic year beginning the following July.
No late applications are accepted.

Please complete and submit this application, a goal statement, your updated CV, three written references and TOEFL scores via mail or **preferably via e-mail** to:

Terri Davis Smith, Academic Specialist, Center for Digestive Health,
Virginia Mason Franciscan Health
1100 9th Ave., P.O. Box 900, Mail Stop: G250-B, Seattle, WA 98101
E-mail: Terri.DavisSmith@virginiamason.org

Letters of recommendation must be addressed to the "Program Director"
and sent in care of Terri Davis Smith

For additional information go to: www.virginiamason.org/ddi. If you experience any difficulties with or have questions about this process, please contact Terri.

PANCREAS RESEARCH FELLOWSHIP APPLICATION

Please Print or Type

PERSONAL DATA

Last Name First Name Middle

Permanent Address:

City State Zip Code

Home Telephone Work Telephone

E-mail Social Security Number

Please note: We cannot consider applicants with J1 visa status. H1B visa may be acceptable.

Is the applicant a US citizen?:

□ Yes

□ No

If no, is the applicant a permanent resident or possess a student or training visa?:

□ Permanent resident of the U.S.

□ Visa – Type and number: _____

Start Date: _____ Expiration Date: _____ Eligible for renewal? Yes _____ No _____

USMLE SCORES **Step I:** Raw/Percentile **Step II:** Raw/Percentile **Step III:** Raw/Percentile

TOEFL READING/WRITING/COMPREHENSION SCORES (For non-native English speakers. Have scores sent directly to Virginia Mason Franciscan Health, Site ID: 3181.)

TOEFL: _____ or **TOEFLiBT: _____** or **TOEFLC:_____**

EDUCATION	NAME OF INSTITUTION	LOCATION	DATES OF ATTENDANCE	DEGREE AWARDED
College				
Medical School				
Graduate School				

POSTGRADUATE TRAINING	NAME OF INSTITUTION	LOCATION	DATES OF ATTENDANCE	DEGREE AWARDED
Internship				
Residency				
Fellowship/Other				

LICENSURE

STATE	DATE OF ISSUE	EXPIRATION DATE	NUMBER

Have you ever been denied a license, permit or privilege of taking an examination by any licensing authority? _____ Yes _____ No

Have you ever had a license of permit encumbered in any way (i.e., revoked, suspended, surrendered, restricted, limited, placed on probation? _____ Yes _____ No

Have you ever been named in a malpractice suit? _____ Yes _____ No

Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation? _____ Yes _____ No

(If you answered yes to any of these questions, please attach a detailed explanation.)

CERTIFICATION

_____

Board Year of Certification

HONORS

_____

_____

Attach a separate page if necessary; do not write "see C.V."

GOAL STATEMENT

Please submit a goal statement addressing your detailed career aim in research; experience with scientific writing, data analysis and endoscopy, and knowledge of statistics and research in a clinical setting, including IRB process, writing protocols, etc.

REFERENCES

Three original letters of recommendations are required; photocopies are not acceptable. One letter must be from the Chief of Service, or Program Director, of all accredited US residencies in which you have served. Phone and email contact information for the reference writer must be included in each letter.

_____ _____

Name Position/Title

_____ _____

Name Position/Title

_____ _____

Name Position/Title

How did you learn of this fellowship program? _____