Beth Israel Deaconess Medical Center

A teaching hospital of Harvard Medical School

BIDMC Cardiac Electrophysiology Application Form

Applying for Fellowship to Begin: ☐ July 2018 ☐ July 2019 ☐ Other _____

1. INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **In addition to completing this application, please submit a curriculum vitae, a brief personal statement (1 page maximum), and 3 references to:**

Alfred Buxton, M.D.
EP Fellowship Program Director
BIDMC
185 Pilgrim Road, Baker 4
Boston, MA 02215
Email: jdwhite@bidmc.harvard.edu
Phone: 617/632-7828
Fax: 617/632-7536

Completed applications must be received by December 31.

2. IDENTIFYING INFORMATION:

Last Name:_____First:_____ Middle:_____

Home Mailing Address:_____

City, State, Zip Code:_____

Phone (H) _____ (Alternate) Phone Number _____ EMail_____

Social Security #:_____ Birth Date:_____ Country of Birth: _____ US Citizen? __YES __ NO

3. MEDICAL EDUCATION:
(Attach additional sheets if necessary. Reference This Section Number and Title).

Medical School:_____

City_____ State_____ Country_____

Degree Received:_____Date of Graduation (MM/D/YY)_____

If foreign medical school graduate: (ATTACH COPY OF FMG CERTIFICATE)

FMGEMS passed on (date) _____ or ECFMG passed on (date)_____

4. POST GRADUATE TRAINING:
(Attach additional sheets if necessary. Reference This Section Number and Title).

Internship

Institution:_____ Program Director:_____

Mailing Address:_____

City, State, Zip Code:_____

Type of Internship:_____

Start Date: _____End Date:_____

Residency

Institution:_____ Program Director:_____

Mailing Address:_____

City, State, Zip Code:_____

Type of Residency:_____

Start Date: _____End Date:_____

Fellowship

Institution:_____ Program Director:_____

Mailing Address:_____

City, State, Zip Code:_____

Type of

Fellowship:_____

Start Date: _____End Date:_____

Other

Institution:_____ Program Director:_____

Mailing Address:_____

City, State, Zip Code:_____

Type of Training:_____

Start Date: _____End Date:_____

5. MEDICAL LICENSURE/REGISTRATIONS

State Medical License Number:_____

State_____Issue Date: _____ Expiration Date:_____

Drug Enforcement Administration (DEA) Registration Number:_____

Expiration Date:_____

State Controlled Substances Certificate (if applicable): _____

Expiration Date: _____

ECFMG Number (applicable to foreign medical graduates): _____

Date Issued: _____Valid Through: _____

6. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held. (Attach additional sheets if necessary. Reference This Section Number and Title).

State: _____ License Number: _____Expiration Date:_____

State: _____ License Number: _____Expiration Date:_____

7. Please provide a brief statement of prior research experience (if any). Attach additional sheets if necessary.

_____
_____
_____
_____
_____
_____

8. REFERENCES. Three references are required. One should be from your Cardiology Fellowship Director.

1. Name _____ Title:_____
   Address: _____
   Phone:_____Email:_____

2. Name _____ Title:_____
   Address: _____
   Phone:_____Email:_____

3. Name _____ Title:_____
   Address: _____
   Phone:_____Email:_____

► _____ _____

Applicant Signature **Date**