



SUNY HEALTH SCIENCE CENTER AT BROOKLYN AFFILIATED HOSPITALS

**Kings County Hospital Center
Staten Island University Hospital**

**Long Island College Hospital
University Hospital of Brooklyn**

Application for Neurology Residency / Fellowship

PROGRAM DIRECTOR _____	SERVICE APPLIED TO _____	YEAR: _____
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- a. RESIDENCY: in the 1st 2nd 3rd 4th 5th 6th year of post-medical school
- b. SUBSPECIALTY. RESIDENCY OR FELLOWSHIP IN THE 1st 2nd 3rd 4th 5th
 6th year of post-medical school training
- c. RESEARCH FELOWSHIIP: (Indicate Specialty or service) _____ Full-time Part-time

LAST NAME	FIRST	MIDDLE	SOCIALSECURITY NUMBER
CURRENTADDRESS (Street, city/State, Zip)			PHONE
LOCALADDRESS (Street, City/State, Zip)			PHONE
EMERGENCY CONTACT PERSON (Name and Address)			PHONE
NEMP NUMBER			

UNDERGRADUATE EDUCATON/COLLEGE	CITY	STATE	YEAR GRADUATED	DEGREE (SPECIFY)

MEDICAL/DENTAL COLLEGE	CITY	STATE	FROM	TO	GRADUATED (MO/YR)

I was will be granted a diploma as DO DDS DMD MD

ECFMG # _____	ISSUE DATE _____	EXPIRATION DATE _____
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ONE OF THESE ITEMS MUST BE COMPLETED BY GRADUATES OF FOREIGN MEDICAL SCHOOLS, INCLUDING U.S. CITIZENS.

- a. I have a standard Certificate from the Educational Council for Foreign Medical Graduates and am attaching a photocopy.
- b. I took the exam on (*Month, Day, Year) _____, and am awaiting the results.
- c. I will file application with ECFMG to have my medical education credentials evaluated and to receive permission to take the examination. Indicate date on which application will be filed (Month, Day, Year)_____.
- d. English Proficiency Exam completed _(date)_____
- e. CSA Exam completed_(date)_____
- f. Test of English as a Foreign Language (TOEFL)

Has there ever been any action taken against you for professional misconduct or malpractice or has any disciplinary action been taken Concerning you performance in prior residency training positions or in medical school? NO YES

If yes supply any information _____

VISA STATUS Permanent Resident (PR) U.S. Born Naturalized Citizen (NC) J-1 H-1B Other

PROFESSIONAL POST-GRADUATE HOSPITAL OR INSTITUTIONAL EXPERIENCE

HOSPITAL OR INSTITUTION	CITY&STATE	TITLE & PGY (Int,Res,Fellow)	SPECIALTY OR SERVICE	FROM Mo/Day/Yr	TO Mo/Day/Yr

I have already passed the examinations checked below on the dates indicated:

- USMLE, STEP I ___(date/score)_____ USMLE, STEP II ___(date/score)_____
- USMLE, STEP III ___(date/score)_____

I am scheduled to take the following exam on the date indicated _____

I have a full and unrestricted license to practice medicine in New York State or another of the U.S., territory of the U. S. and/or U.S. possession: Yes No

New York State License No. _____ Year _____

Other state, territory or possession licensed in _____ License No. _____ Year _____

This application must be accompanied or followed by a Curriculum Vitae and Bibliography, a Personal Statement, a Dean's Letter and transcript from the applicant's medical school, and letters of recommendation from three physicians who have worked with the applicant in the last 3 years. If the applicant is currently enrolled in a residency program (e.g., PGY1 or other) a letter from that program director must also accompany this application. Copies of USMLE scores and a copy of the applicant's NEMP registration must also be submitted.

Acknowledgement of receipt of application by Email? No Yes E-mail Address _____

I certify that all information provided is true and accurate. I understand that any misleading or false information may be sufficient cause for immediate dismissal in the event of my appointment to this SUNY residency program.

Signature _____ Date _____

Please address adult residency applications to:

Lisa Merlin, M.D.
 Adult Neurology Residency Director
 c/o Ms. Marian James
 Residency Coordinator, Department of Neurology
 State University of New York Health Science Center at Brooklyn
 450 Clarkson Avenue, Box 1213
 Brooklyn, NY 11203
 Telephone: (718) 270-2945
 Fax (718) 270-3840
 E-mail: mjames@downstate.edu

Please address pediatric neurology fellowship applications to:

Joan Cracco M.D.
 Director, Division of Pediatric Neurology
 State University of New York Health Science Center at Brooklyn
 450 Clarkson Avenue, Box 18
 Brooklyn, NY 11203
 Telephone: (718) 2042
 Fax (718) 270-3748
 E-mail: jcracco@downstate.edu

Please address Electrophysiology Fellowship Application to:

Susan T. Herman, M.D.
 c/o Ms. Mary Noto
 Director
 Clinical Neurophysiology Fellowship Program
 SUNY Health Science Center at Brooklyn
 450 Clarkson Ave., Box 1213
 Brooklyn, NY 11203
 Telephone: (718) 270-2959
 Fax: (718) 270-6348
 E-mail: susan_herman@downstate.edu