Glaucoma Associates of New York

The New York Eye and Ear Infirmary

310 East 14th Street
New York New York 10003
(212) 477-7540
Fax: (212) 420-8743

APPLICATION FOR FELLOWSHIP

FULL NAME: (Print):

_____

DATE/PLACE OF BIRTH:

_____

Home Address & Phone

_____
_____
_____
Tel: _____
Fax: _____
E-Mail: _____

Department/Office Address & Phone

_____
_____
_____
Tel: _____
Fax: _____
E-mail _____

Marital Status: Single _____ Married _____

Spouse' Name _____

Social Security No.: _____

Fellowship Match No.: _____

Type of Fellowship Desired: _____ 1 year clinical _____ 2 years clinical/research

Dates of Appointment Preferred: _____

Premedical & Medical Education (Have Transcripts Forwarded From Medical School):

Undergraduate School	City & State	Dates Attended	Degree

_____

Medical School	City & State	Dates Attended	Degree

_____

National Boards:

Part I: Date_____ Score _____
Part II: Date_____ Score _____
Part I I I: Date _____ Score _____

Internship (give name of institution, city, state and dates):

_____

Residency (give name of institution, city, state and dates):

_____

Other Professional Experience (give institutions, titles held and dates):

Previous Training in Ophthalmology:

Academic Honors. Scholarships, Fellowships. Publications:

U.S. Citizen _____Other _____ (specify and indicate type of visa held) _____

Medical Licensure: (give state, date and license number):_____

(If not citizen of U.S., temporary license to practice in New York required before beginning fellowship)

Foreign Medical Graduates – ECFMG Examination: (If Applicable)

Date Taken: _____ Scaled Score: _____ Certificate No.: _____

ATTACH PHOTO HERE (2X2 inches)

_____ _____

Date of Application Signature of Applicant

Please attach a 300 to 500 word statement describing what you expect to
achieve from the glaucoma fellowship and what you envision your future plans to consist of.
Letters of recommendation should be sent by at least three professional associates.