

Ahmanson/UCLA Adult Congenital Heart Disease Center
Dedicated to the Future of Children

David Geffen School of Medicine
Departments of Medicine, Pediatrics & Surgery
UCLA Center for the Health Sciences
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E-mail: ACHDC@mednet.ucla.edu
Website: www.uclahealth.org/achd

Ahmanson/UCLA Adult Congenital Heart Disease Fellowship Application

Dear applicant,

Thank you for your interest in the Ahmanson/UCLA Adult Congenital Heart Disease Fellowship Training Program commencing July 2016. The following information is required for your application to be considered:

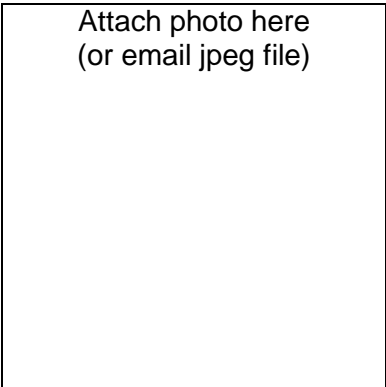
- Completed fellowship application
- Current Curriculum Vitae
- Personal statement (1 page)
- Medical school transcript. A translation must be provided if in a language other than English
- Dean's Letter/Performance Evaluation
- Three letters of recommendation. One must be from your adult or pediatric cardiology fellowship program director
- Copies of United States Medical Licensing Exam (USMLE) scores
- ECFMG Certificate if you are a graduate of a medical school outside of the US or Canada

Your applications materials and supporting documents should be emailed (preferred), mailed or faxed to:

Jeannette Lin, Ahmanson/UCLA ACHD Fellowship Program Director
jeannettelin@mednet.ucla.edu
Fax: 310-825-6346

Mailing address:

Ahmanson/UCLA Adult Congenital Heart Disease Center
650 Charles E. Young Dive South, Room A2-237 CHS Los Angeles, CA 90095



APPLICANT INFORMATION

Name (First Middle Last)
Current mailing address
Street:
City:
State:
Zip/Postal Code:
Phone number:
Email:
Social Security (U.S. only):
Date of Birth:
Gender (M/F):

UNDERGRADUATE, MEDICAL SCHOOL AND POST GRADUATE EDUCATION

Institution:
Degree/Position: Dates (from/to):
City: State: Country:

Institution:
Degree/Position: Dates (from/to):
City: State: Country:

Institution:
Degree/Position: Dates (from/to):
City: State: Country:

Institution:
Degree/Position: Dates (from/to):
City: State: Country:

Institution:
Degree/Position: Dates (from/to):
City: State: Country:

Please explain any gaps in education:

MEDICAL LICENSURE AND EXAMINATIONS

1. Please list your medical license information below.

State: Number: Expiration date (m/d/yyyy): <input type="checkbox"/> Permanent/full <input type="checkbox"/> Limited
State: Number: Expiration date (mm/dd/yyyy): <input type="checkbox"/> Permanent/full <input type="checkbox"/> Limited
State: Number: Expiration date (mm/dd/yyyy): <input type="checkbox"/> Permanent/full <input type="checkbox"/> Limited

2. Please list your USMLE results below (Copies of results are required)

Step 1	Score	Date passed (m/yyyy):
Step 2 CK	Score	Date passed (m/yyyy):
Step 2 CS	Score	Date passed (m/yyyy):
Step 3	Score	Date passed (m/yyyy):

3. If you are a Canadian Medical Graduate, please provide copies of Medical Council of Canada (MCC) scores.

LETTERS OF RECOMMENDATION

Please list the name, title, and full address of three people who will write letters of recommendation on your behalf. If is required that one letter be completed by your adult/pediatric cardiology fellowship program director.

Name: Title: Street address: City: State/Country: Zip/Postal Code: Phone number:
Name: Title: Street address: City: State/Country: Zip/Postal Code: Phone number:
Name: Title: Street address: City: State/Country: Zip/Postal Code: Phone number:

I certify that the above information is true and correct to the best of my knowledge.

Applicant's Signature

Date (mm/dd/yyyy)