

APPLICATION FOR MATERNAL-FETAL MEDICINE FELLOWSHIP PROGRAM

I. APPLICANT IDENTIFICATION

Name: _____
Last First Middle

Present Address: _____
Street City State Zip

Permanent Address: _____
Street City State Zip

Telephone Number: (_____) _____ (_____) _____
Office Home

Social Security Number: _____

Date of Birth: _____ Place of Birth: _____

Citizenship: _____

II. EDUCATIONAL BACKGROUND

A. Undergraduate Education:

College or University Dates Degree

College or University Dates Degree

B. Medical Education:

Medical School Dates Degree

Medical School Dates Degree

Was there an interruption in your Medical School training?

Yes
No

If yes, please explain: _____

C. Have you ever been reprimanded or disciplined by a licensing board or made to appear before a licensing board for allegations of misconduct or wrongdoing?

Yes

No

Date: _____

D. Has your license (issued by any state) ever been suspended, revoked, or restricted?

Yes

No

Date: _____

E. If you answered **Yes** to C. or D. above, please explain:

IV. CERTIFICATION IN OBSTETRICS AND GYNECOLOGY

A. Have you made application for the written examination?

Yes

No

Date: _____

B. Have you passed the written examination?

Yes

No

Date: _____

C. Have you made application for the oral examination?

Yes

No

Date: _____

D. Have you passed the oral examination?

Yes

No

Date: _____

V. Employment and Hospital Privileges

A. Briefly explain your employment record (up to the last five years) if other than residency training:

B. Please list current and past Hospital Privileges:

_____	_____	_____
Hospital Name	City, State	Dates
_____	_____	_____
Hospital Name	City, State	Dates
_____	_____	_____
Hospital Name	City, State	Dates
_____	_____	_____
Hospital Name	City, State	Dates

C. Have you ever had any hospital privileges suspended, revoked, or restricted?

Yes

No

If yes, please explain:

VI. PERSONAL DATA

A. Please summarize your professional interests and goals:

B. What features of the University of Texas program interest you?

C. Have you ever been party to a medical malpractice claim?

Yes

No

How may times? _____

If yes, please attach a brief description for each incident

D. Hobbies

VII. Letters of Recommendation have been requested from the following

Name _____ Address _____ Position _____

Name _____ Address _____ Position _____

Name _____ Address _____ Position _____

Name _____ Address _____ Position _____

VII. SUPPORTING DOCUMENTS:

- A. Autobiographic statement
- B. Curriculum Vitae
- C. Letters of recommendation (minimum of three, with one from your Residency Program Director and one from the Chief of Service or Chair)

This application and all supporting documents must be sent directly to:

**Manju Monga, MD
MFM Fellowship Program Director
Department of Obstetrics, Gynecology and Reproductive Sciences
The University of Texas Houston Medical School
6431 Fannin, Suite 3.604
Houston, TX 77030**

**AFFIX RECENT
PHOTOGRAPH**

Signature

Date