Family Medicine Obstetrics Fellowship Application

Name: _____
Last First Middle

_____
Present address (street)

_____
(City) (State) (Zip)

Preferred Phone #: _____

Alternate Phone #: _____

E-mail: _____

Birthplace: _____**Citizenship**: _____

If you are **NOT** a citizen of the United States, please complete the following:

Are you a permanent U.S. resident? ☐ Yes ☐ No

Do you require sponsorship? If so, what type of visa: _____

Licensure: Please provide the license number, date issued and state(s)_____

_____

_____

Are any of your licenses limited or temporary?
☐ No ☐ Yes If yes, please explain.

_____

_____

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? ☐ No ☐ Yes. If yes, please explain.

_____

_____

Application Requirements
In addition to this application, you are required to submit the following information:

A Current *Curriculum Vitae* that includes:

Education: List college/university, graduate and professional schools attended. Indicate dates attended, major, degree received, and date received.
Academic honors, scholarships, and other awards you have received.
Post Graduate Training: Indicate dates, institution, location and specialty.
Fellowships Held: Indicate the name of the fellowship, institution and date.
Board/Subspecialty Board Certifications: Indicate number and year.
Research and Publications

Personal Statement describing your interest in this fellowship and your goals.

A copy of your **USMLE and/or COMLEX score report**
A copy of your **In-Training Exam Scores Report**

Official procedure log from residency tracking software documenting:
# of Vaginal Deliveries
# of C-Sections – separate out primary and assist

If you are a graduate of a foreign medical school, you are required to be certified by **the Educational Council for Foreign Medical Graduates (ECFMG)**.
(Please submit a copy of this certificate with this application.)

Three Letters of Recommendation including one from your residency program director or department chair.

I certify that the information contained in this application, including the statement of personal statement and the supporting documents is complete and accurate. I understand that submission of inaccurate information may be sufficient cause for denial or admission or termination of enrollment.

_____	_____	_____
Print name	Signature	Date

Return application with required attachments to:

Reanna Benedict, MEd
Program Administrator, Family Medicine Obstetrics Fellowship
Cape Fear Valley Health - Graduate Medical Education
1638 Owen Drive
Box 138
Fayetteville, NC 28304
Phone (910) 615-0203
Or email to RBenedict@capefearvalley.com