DEPARTMENT OF NEUROLOGY
YALE UNIVERSITY SCHOOL OF MEDICINE AND YALE-NEW HAVEN MEDICAL CENTER
YALE COMPREHENSIVE EPILEPSY CENTER
333 CEDAR STREET
PO BOX 208018
NEW HAVEN, CT 06520-8018

# Epilepsy/EEG Fellowship Application

**Today's Date:**

**Name:**

___________________________________________
*(Last)* *(First)* *(Middle)*

**Current Mailing Address:**

___________________________________________
*(Street)* *(City)* *(State)* *(Zip)*

**Telephone Number:**

___________________________________________
*(Day)* *(Evening)*

**Place of Birth:** ___________________________________________
*(Country, City, State)*

**Citizen of:** ___________________________________________

**Visa Status:** ______________________ **Visa Expiration Date:** ______________________
*(Month/Year)*

**Residency Accreditation:**

- ☐ Accreditation Council for Graduate Medical Education (ACGME)
- ☐ Royal College of Physicians and Surgeons of Canada (RCPSC)
- ☐ Program outside the Unites States and Canada
- ☐ ECFMG Certification Number and Date (if applicable):

**Where did you complete your Residency?**

___________________________________________
*(School Name, Country, State & City)*

**Date you completed your Residency?**

___________________________________________
*(Month & year)*

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**Epilepsy/EEG Fellowship Application**



**Medical School:**

______________________________________________________________________
*(School Name, Country, City & State)*

**Date of your Medical School Graduation (actual date):** ______________________
*(Month/Day/Year)*

**Degree(s) earned:**

☐ D.O.
☐ M.D.
☐ M.B.B.S.
☐ Ph.D.

**Current PGY Level:** ______________________________

**Please indicate which fellowship you are applying for:** ______________________

- o Epilepsy/EEG Fellowship (2 years)
- o ICU-EEG Fellowship (1 year)
- o Epilepsy (one year)
- o Clinical Neurophysiology (1 year)
- o Other:

**I hereby apply for an appointment as a postdoctoral fellow in Epilepsy/EEG from:**

______________________ through ______________________
*(Month/Year)* *(Month/Year)*

***Signature:*** ______________________________