Thank you for choosing OhioHealth to be a part of your educational experience.

APPLICATION PROCESS

Candidates should have a background/interest in Medical Education. While the fellowship is accredited by the American College of Surgeons, applications will be accepted from physicians outside of surgical specialties as well as from those individuals with advanced education degrees. International candidates and those with interrupted training tracts or careers will be considered. For those wishing to pursue clinical opportunities, a combined fellowship/work schedule may be possible. An advanced educational degree program may be available to those candidates who wish to pursue this opportunity.

Directions: Please be sure to thoroughly read and complete every section of this application. If a section does not apply to you please write N/A in the section. The application will not be considered complete until all of the additional items listed in **Section C** of this application have been received. The completed application should be submitted via email to the OhioHealth Graduate Medical Education Department, at **rmhmeded@ohiohealth.com.**

You will be notified on the status of your application within two weeks of submission of all requested documents.

SECTION A: Applicant Information

Name: _____ **Date of application:** ___/___/____
Last First MI

Professional Designation (i.e. MD, PhD): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: (_____) _____ **E-Mail Address:** _____

DOB: ____/_____/_____ **Gender:** ❑ male ❑ female ❑ other/prefer not to state

Education and Experience

❑ Residency training:

Full Program Name (include specialty): _____

Program Director Name: _____

Dates of Training: ____/____/_____ to ____/____/_____ ❑ AOA ❑ ACGME

Full Program Name (include specialty): _____

Program Director Name: _____

Dates of Training: ____/____/_____ to ____/____/_____ ❑ AOA ❑ ACGME

❑ I am currently in practice (please list past 10 years, attach additional if necessary):

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Dates of employment: ____/____/_____ to ____/____/_____

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Dates of employment: ____/____/_____ to ____/____/_____

Licensure

State Medical Licensure

❑ I hold a medical license in the state of Ohio.

License Number: _____ Dates Valid: _____

❑ I hold a medical license in another state.

State: _____ License Number: _____ Dates Valid:_____

❑ I hold a current training certificate/training license.

State: _____ License Number: _____ Dates Valid:_____

Have you ever been convicted of a felony or misappropriation of funds? ❑ yes ❑ no

Describe if yes: _____

Are there any actions or proceedings which have involved the suspension or revocation of your license or training permit in any state or jurisdiction? ❑ yes ❑ no

Describe if yes: _____

SECTION B: Graduates of Medical Schools Outside the United States

OhioHealth considers applicants without regard to race, color, religion, gender, national origin, marital or veteran status, disability, or any other legally protected status.

ECFMG Certificate Number: _____ Date Issued:_____

Immigration Status (if non US citizen):_____

SECTION C: Required Additional Items

The items listed below must be received by OhioHealth Riverside Methodist Hospital Graduate Medical Education prior to application review.

- ❑ Current CV
- ❑ Cover letter outlining your professional goals and reason for pursuing this fellowship
- ❑ Notarized copy of your residency training completion certificate, if applicable
- ❑ A color photograph (digital or .jpeg)
- ❑ 2 letters of recommendation, one from your program direction or an equivalent program faculty member and one from another professional colleague

Please have your references mail letters of recommendation to:
Brad Gabel, MD
c/o Audra Lusk
Riverside Medical Education, Simulation Fellowship
3535 Olentangy River Road
Columbus, Ohio 43214

Or by email to:
Brad.gable2@ohiohealth.com
Audra.lusk@ohiohealth.com

SECTION D: Acknowledgement

Authorization and Release: To the best of my knowledge, the information that I have provided in this application is true and free of any consequential omissions. I authorize OhioHealth Riverside Methodist Hospital Graduate Medical Education to verify any of the information I have provided, and further authorize any of the schools, institutions, or persons listed to provide any information about me contained in their records. If I am accepted for any position by OhioHealth Riverside Methodist Hospital, I agree to abide by the policies, rules, regulations and practices of OhioHealth Riverside Methodist Hospital.

Signature: _____ **Date:** _____

Printed Name: _____