STANFORD
SCHOOL OF MEDICINE

STANFORD UNIVERSITY SOM APPLICATION
HEADACHE FELLOWSHIP

Applying for the year to start: 20 ____ 20 ____

Name:	**E-mail Address:**
Mailing Address:	**Home Telephone: ( )**
Work Telephone: ( )	**Date of Birth:**
Place of Birth:	**Gender:**
Name, Address & Telephone number of next of kin or other person for permanent contact:	

NON-MEDICAL DEGREES:

COLLEGE / GRADUATE SCHOOL	DEGREE	DATE GRADUATED

MEDICAL DEGREES:

MEDICAL SCHOOL	DEGREE	DATE GRADUATED

United States Medical Licensing Examination (USMLE)

Step 1: Score_____ Date:_____	
Step 2: CK Score_____ Date:_____	CS Score _____ Date:_____
Step 3: Score_____ Date:_____	

California laws require that all residents and fellows hold a state license. Those who DO NOT HAVE such a license must take and pass the next examination following commencement of service, or obtain licensure by reciprocity with National Boards or another state.

Medical Licensure (License Number and State): ***Is this a temporary or training license?*** ***Yes*** ☐ ***No*** ☐
Internship/Location and Specialty:
Residency/Location and Specialty:
Fellowship/Location and Specialty:
Membership in Scientific and Professional Organizations:

If you have ever left any course of residency, internship or fellowship for any reason other than the expiration of the usual term, please state the reason(s):
Research in Progress:
Publications and Abstracts:
Present State of Health:
Do you have any physical or mental health impairments?

Signature: _____ ***Date:*** _____