

**General Information** (to be filled out by Applicant)

\_\_\_\_\_  
(First name) (Middle initial) (Last name)

Degree: \_\_\_\_\_

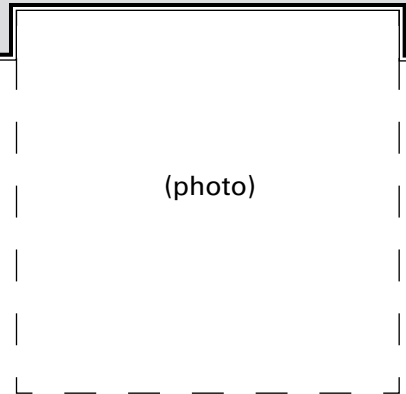
Citizenship: \_\_\_\_\_ Email: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_ Office Phone: \_\_\_\_\_



**Work Information**

Title: \_\_\_\_\_

Nature of Work: \_\_\_\_\_

Other Affiliations: \_\_\_\_\_

I am applying for:

- One year fellowship (Medical trainees, MBAs, Engineers)
- Two year fellowship (Medical trainees only)

**Contact Information** (Please enter all contact numbers and indicate your preferred method.)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Pager: \_\_\_\_\_

Preferred Contact Type: \_\_\_\_\_

**Other Personal Information**

Gender:  Male  Female Ethnicity: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Place of Birth: City/State \_\_\_\_\_ Country: \_\_\_\_\_

If NOT a U.S. citizen, do you have a U.S. permanent resident visa (U.S. green card)?

Yes  No

Have you ever been convicted of a felony?  Yes  No

If Yes, please explain: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

If from a website, please list the URL: \_\_\_\_\_

**Medical Education**

Institution & Location	Dates Attended (mm/yy)	Degree	Date of Degree
Medical Education Extended or Interrupted?		Reason:	

**Graduate Education**

Institution & Location	Dates Attended	Degree	Date of Degree	Field of Study

**Undergraduate Education**

Institution & Location	Dates Attended	Degree	Date of Degree	Field of Study

**Educational Honors/Awards:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Residency Experience** (account for all dates from receipt of your college degree to present)

Institution	Program Director/ Supervisor	Dates Attended	Years	Specialty	Reason for Leaving

**Work Experience** (account for all dates from receipt of your college degree to present)

Organization	Position	Dates	Description	Reason for Leaving

**Volunteer Experience** (account for all dates from receipt of your college degree to present)

Organization	Position	Dates	Description

**Research Experience** (account for all dates from receipt of your college degree to present)

Organization	Position	Dates	Supervisor	Description

**Hobbies & Interests:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Awards/Accomplishments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reference #1**

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Institution/Organization: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax : \_\_\_\_\_  
Email: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Comments: \_\_\_\_\_

\*Medical applicants must have reference from current or last Director of Program.  
\*MBA/Engineer must have reference from current or last employer.

**Reference #2**

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Institution/Organization: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax : \_\_\_\_\_  
Email: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Comments: \_\_\_\_\_

**Reference #3**

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Institution/Organization: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax : \_\_\_\_\_  
Email: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Comments: \_\_\_\_\_

**Medical Licensure** (if applicable)

Current Medical Licensure:	
Medical License Citation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason:
Controlled Substance Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason:
Current malpractice case(s) pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason:

I certify that all information in this application is true and no material omissions have been made.

Certified by: \_\_\_\_\_

Date: \_\_\_\_\_

Please send us your curriculum vitae. Note: to submit applications via email (UM-MIC@med.umich.edu), the total size of your completed application must be less than 10MB. Confirm receipt of any documents sent electronically by contacting our office.

Return completed applications to:

University of Michigan Medical Innovation Center  
24 Frank Lloyd Wright Drive  
P.O. Box 462  
Ann Arbor, MI 48106