



Vanderbilt Emergency Medicine K12 Research Training Program Application for 2012

THANK YOU FOR YOUR INTEREST IN OUR PROGRAM.

INSTRUCTIONS:

- APPLICATIONS AND LETTERS OF RECOMMENDATION MUST BE RECEIVED BY MARCH 1, 2012.
- YOUR APPLICATION WILL BE COMPLETE WHEN WE HAVE THE FOLLOWING:
 1. COMPLETE APPLICATION FORM
 2. CURRICULUM VITAE
 3. PERSONAL STATEMENT
 4. THREE LETTERS OF RECOMMENDATION

MAILING ADDRESS:

ALAN B. STORROW, MD
DIRECTOR, VEMRT K12 PROGRAM
VANDERBILT UNIVERSITY
1313 21ST AVE, SOUTH 703 OXFORD HOUSE
NASHVILLE, TN 37232-4700

FOR ADDITIONAL INFORMATION:

LYNDI GOETTE - PROGRAM COORDINATOR
PHONE: 615-936-0253
FAX: 615-936-4490
EMAIL: LYNDI.E.GOETTE@VANDERBILT.EDU

RACIAL / ETHNIC CLASSIFICATIONS AS DEFINED BY THE NATIONAL INSTITUTE OF HEALTH:

AMERICAN INDIAN OF ALASKAN NATIVE: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF NORTH AMERICAN AND WHO MAINTAINS CULTURAL IDENTIFICATION THROUGH TRIBAL AFFILIATION OR COMMUNITY RECOGNITION

ASIAN PACIFIC ISLANDER: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF THE FAR EAST, SOUTHEAST ASIA, THE INDIAN SUBCONTINENT, OF THE PACIFIC ISLANDS. THIS AREA INCLUDES CHINA, INDIA, JAPAN, KOREA, THE PHILIPPINE ISLANDS AND SAMOA.

BLACK, NOT OF HISPANIC ORIGIN: A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA

HISPANIC: A PERSON OF MEXICAN, PUERTO RICAN, CUBAN, CENTRAL OR SOUTH AMERICAN OR OTHER SPANISH CULTURE OR ORIGIN

WHITE, NOT OF HISPANIC ORIGIN: A PERSON HAVING ORIGINS IN ANY OF THE ORIGINAL PEOPLES OF EUROPE OR THE MIDDLE EAST

PERSONAL INFORMATION

LAST NAME: FIRST NAME: MIDDLE I.: SUFFIX:

ADDRESS: CITY:

STATE: ZIP CODE: COUNTRY:

PHONE NUMBER: EMAIL ADDRESS:

DATE OF BIRTH: MALE: FEMALE:

SOCIAL SECURITY #:

US PERMANENT RESIDENT OR CITIZEN? YES NO

ETHNIC ORIGIN (FOR NIH REPORTING PURPOSES ONLY - SEE DEFINITIONS ON INSTRUCTIONS PAGE)

AMERICAN INDIAN OR ALASKAN NATIVE

ASIAN OR PACIFIC

BLACK, NOT OF HISPANIC ORIGIN

HISPANIC

WHITE, NOT OF HISPANIC ORIGIN

EDUCATION

UNDERGRADUATE:

SCHOOL:

ADDRESS:

DEGREE: FIELD OF STUDY:

DATES OF ATTENDANCE:

GRADUATE:

SCHOOL:

ADDRESS:

DEGREE: FIELD OF STUDY:

DATES OF ATTENDANCE:

MEDICAL SCHOOL:

SCHOOL:

ADDRESS:

DEGREE: FIELD OF STUDY:

DATES OF ATTENDANCE:

POST GRADUATE EDUCATION (Please include complete address)

RESIDENCY TRAINING:

SPECIALTY:

HOSPITAL:

PROGRAM DIRECTOR:

ADDRESS:

DATES OF ATTENDANCE:

FELLOWSHIP TRAINING (If Applicable):

SPECIALTY:

HOSPITAL:

PROGRAM DIRECTOR:

ADDRESS:

DATES OF ATTENDANCE:

OTHER TRAINING/EXPERIENCE:

SPECIALTY:

HOSPITAL:

PROGRAM DIRECTOR:

ADDRESS:

DATES OF ATTENDANCE:

REFERENCES: Please list the full name, telephone number and email address of three individuals who will provide letters of recommendation. One letter should be from your current program director.

NAME:

EMAIL ADDRESS:

TELEPHONE:

NAME:

EMAIL ADDRESS:

TELEPHONE:

NAME:

EMAIL ADDRESS:

TELEPHONE:

PLEASE PASTE A COPY OF YOUR PERSONAL STATEMENT HERE OR SEND TO US VIA EMAIL. YOU MAY ALSO INCLUDE A SHORT DESCRIPTION OF YOUR RESEARCH GOALS AND FOCUS AREAS YOU ARE INTERESTED IN.

PERSONAL STATEMENT CONTINUED