

UNIVERSITY OF KENTUCKY  
MEDICAL CENTER-MARKEY CANCER CENTER  
LEXINGTON, KENTUCKY 40536

APPLICATION – FELLOWSHIP GYNECOLOGIC ONCOLOGY

PLEASE PRINT OR TYPE

NAME \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
LAST FIRST MIDDLE  
PRESENT ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
PERMANENT ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ CITIZENSHIP \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ NO. CHILDREN \_\_\_\_\_

EDUCATION AND TRAINING:

COLLEGE \_\_\_\_\_ LOCATION \_\_\_\_\_ YEARS ATTENDED \_\_\_\_\_ GRADUATED \_\_\_\_\_  
MEDICAL SCHOOL \_\_\_\_\_ YEAR GRADUATED \_\_\_\_\_ DEAN \_\_\_\_\_  
ADDRESS \_\_\_\_\_ (SUBMIT TRANSCRIPT OF RECORD)

CLERKSHIP: HOSPITAL \_\_\_\_\_ LOCATION \_\_\_\_\_ DATES \_\_\_\_\_  
HOSPITAL \_\_\_\_\_ LOCATION \_\_\_\_\_ DATES \_\_\_\_\_  
INTERNSHIP: HOSPITAL \_\_\_\_\_ LOCATION \_\_\_\_\_ DATES \_\_\_\_\_

RESIDENCIES:  
HOSPITAL \_\_\_\_\_ LOCATION \_\_\_\_\_ DATES \_\_\_\_\_ SERVICE \_\_\_\_\_  
HOSPITAL \_\_\_\_\_ LOCATION \_\_\_\_\_ DATES \_\_\_\_\_ SERVICE \_\_\_\_\_

LICENSED TO PRACTICE: STATE \_\_\_\_\_ #: \_\_\_\_\_ DATE \_\_\_\_\_  
STATE \_\_\_\_\_ #: \_\_\_\_\_ DATE \_\_\_\_\_

REFERENCES: LIST THREE PHYSICIANS AND REQUEST LETTER TO BE SENT AS DIRECTED BELOW

PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_

- INSTRUCTIONS:
1. Attach a passport size photograph.
  2. Attach a curriculum vitae and a personal statement.
  3. Complete application and forward to J.R. van Nagell, Jr., M.D., Director, Division of Gynecologic Oncology, Dept. of Ob/Gyn, University of Kentucky Medical Center, 800 Rose Street, Lexington, KY 40536