# Chiang Mai University
# Nephrology Fellowship Application Form

---

**Profile**

First Name: _____ Last Name: _____

Preferred Phone: _____ Mobile: _____

Contact E-mail _____

Birth Place: _____ Birth Date: _____ Age: _____

Race: _____

**Present Mailing Address:**

Street Address: _____

City: _____ Province: _____ Postal Code: _____

**Medical license ID**: _____

**Permanent Mailing Address:**

Street Address: _____

City: _____ Province: _____ Postal Code: _____

**Medical Education**

**Entry 1: Doctor of Medicine**

Institution: _____

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month: _____ Year: _____

To: Month: _____ Year: _____

**Entry 2: Board of Internal Medicine**

Institution: _____

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month: _____ Year: _____

To: Month: _____ Year: _____

**Current Training**

For residency or fellowship training position you have **currently** are in.

**Entry:**

Type of Training: Residency Fellowship

Specialty: _____

Institution/Program: _____

Dates of Residency/Fellowship training:

From: Month: _____ Year: _____

To: Month: _____ Year: _____ (*Leave month/year blank if training is ongoing*)

**Experience(s)**

Provide the requested information for each relevant work, research, and volunteer experience/position. Include clinical and teaching experience as work experiences, and include all unpaid extracurricular activities and committees you have served on as volunteer experiences. If you have no experience to enter, please select **None**.

**None**

**Entry 1:** Experience Type: Work Research Volunteer

Organization: _____

Position: _____ Supervisor: _____

Description:

_____

_____

_____

Dates of Experience:

From: Month: _____ Year: _____

To: Month: _____ Year: _____ (*Leave month/year blank if experience is ongoing*)

**Entry 2:** Experience Type: Work Research Volunteer

Organization: _____

Position: _____ Supervisor: _____

Description:

_____

_____

_____

Dates of Experience:

From: Month: _____ Year: _____

To: Month: _____ Year: _____ (*Leave month/year blank if experience is ongoing*)

**Application – Publications**

For each publication/presentation, please provide the requested information. If you have no publications to enter, select **None**.

**None**

**Peer Reviewed Journal Articles/Abstracts 1:**

Title: _____

Author(s): _____
_____
_____

Publication Name: _____

Volume: _____ Issue No: _____ Pages: _____ Month: _____Year: _____

Publication Status: Submitted, Provisional Accepted, or In-Press

**Peer Reviewed Journal Articles/Abstracts 2:**

Title: _____

Author(s): _____
_____
_____

Publication Name: _____

Volume: _____ Issue No: _____ Pages: _____ Month: _____Year: _____

Publication Status: Submitted, Provisional Accepted, or In-Press

**Peer Reviewed Journal Articles/Abstracts 3:**

Title: _____

Author(s): _____
_____
_____

Publication Name: _____

Volume: _____ Issue No: _____ Pages: _____ Month: _____Year: _____

Publication Status: Submitted, Provisional Accepted, or In-Press

**Book Chapter:**

Chapter Title: _____

Name of Book: _____

Author(s): _____
_____
_____

Editor(s): _____ Pages: _____

**Poster Presentation:**

Poster Presentation Title:
_____

Author(s): _____
_____
_____

Event/Meeting: _____

Country: _____ Month: _____ Year: _____

**Oral Presentation:**

Oral Presentation Title:
_____

Author(s): _____
_____
_____

Event/Meeting: _____

Country: _____ Month: _____ Year: _____

**Application – Medical Licensure**

Has your medical license ever been suspended/voluntarily terminated?

**Yes No**

Reason (if Yes):

_____
_____
_____

Was your medical education/training extended or interrupted?

**Yes No**

Reason (if Yes):

_____
_____
_____

**Application – Miscellaneous**

Hobbies and Interests:

_____
_____
_____

Medical School Awards:

_____
_____
_____

Other Awards/Accomplishments:_____
_____
_____
_____

I certify that the information contained within my application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; or if employed, may constitute cause for termination from the program.

Signature _____

Date (D/M/Y): _____

Other documents required with this application form

____ Two photographs, 1x1 or 2x2 inches in size

____ One copy of medical license

____ One copy of certificate of Board of Internal medicine

____ One copy of national identification card