



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
- One copy of transcript
- Recommendation letter