



# The University of Utah

Moran Eye Center 

*Instructions: Complete the following form, save the file, and e-mail the file to [elaine.schwanebeck@hsc.utah.edu](mailto:elaine.schwanebeck@hsc.utah.edu)*

- Cornea and Refractive Surgery     Glaucoma     Neuro-ophthalmology     Retina

## PERSONAL INFORMATION

**San Francisco Match #**

<b>Name</b>	
<b>Address</b>	<b>Day Phone</b>
	<b>Evening Phone</b>
	<b>Cell Phone or pager</b>
	<b>E-Mail</b>
<b>Citizenship</b>	<b>U.S. Visa Status</b>

## EDUCATION

*List your college, medical school, and graduate level experience in chronological order.*

School/Medical Facility/Institution	Major/Specialty	Dates Attended	Degree	GPA

## EXAMINATIONS

*Please list those appropriate to your application*

USMLE Step 1 _____	Step 2 _____	Step 3 _____	(dates)
FLEX Component 1 _____	FLEX Component 2 _____		(dates)
NBME Part 1 _____	Part 2 _____	Part 3 _____	(dates)
ECFMC Certification Date: _____	Certificate # _____		
FMGEMS Day 1 _____	Day 2 _____		

**SPECIAL ACTIVITIES**

**Honors, Awards and Achievements**

**Employment History**

**Career Objectives**

**Research Activities, Papers and/or Additional Information**

**PERSONAL STATEMENT**

**REFERENCES**

*Three Letters of Reference (one from your department chair) should be sent to Elaine Schwanebeck, Academic Program Coordinator, John A. Moran Eye Center, 65 North Medical Drive, Salt Lake City, Utah 84132*

Name	Title	Institution

- I waive access to these letters and have informed the authors of this confidentially. I understand that these letters will not be returned.
- I desire access to these letters and have informed the authors.

**CERTIFICATION STATEMENT** *(Check box to certify statement. If box is not checked, application will not be reviewed.)*

I certify that the information in this application is true and complete and that I have not withheld information that might significantly affect my qualifications for fellowship training in the Department of Ophthalmology & Visual Sciences of the John A. Moran Eye Center, University of Utah School of Medicine. I authorize the Department of Ophthalmology & Visual Sciences to contact any or all of my former employers, educational institutions and/or other persons or organizations that may have information pertinent to my application. I understand my application and its full contents will be held in the strictest confidence. I intend to verify completion of all prerequisites before the start of my training if I am chosen and any contract will be void if said prerequisites are not completed.