

CARDIOVASCULAR FELLOWSHIP TRAINING PROGRAM

New Application Packet

Jefferson Health NJ – Virtua Our Lady of Lourdes (VOLOL) Cardiovascular Fellowship program is administered by Virtua Cardiology.

Our three year program is one of the few osteopathic programs nationwide that provides training and eligibility to be Level II certified in the following three areas:

- Diagnostic cardiac catheterization
- Nuclear Cardiology
- Transesophageal and transthoracic echocardiography

Our adult cardiovascular training program provides complete training in invasive and non-invasive cardiology. State of the art patient care and graduate medical education is provided by Virtua Our Lady of Lourdes Hospital and the Jefferson Health NJ System.

Attached you will find an application along with an application checklist, which outlines all required supporting documentation. Please note all letters of recommendation and transcripts must be originals, sent directly from the sending physician or institution to our program, and current within 90 days.

Please complete and return your application to me at:

**1 Brace Road Suite C
Cherry Hill New Jersey 08034**

If you have any comments, questions or concerns; or if I can be of any assistance to you during the application process please do not hesitate to call me at 856-755-1173. Thank you for your interest in our program.

Kelly Broome
Program Coordinator
Jefferson Health NJ – Virtua OLOL Cardiovascular Training Program
kbroome@virtua.org

**PLEASE BE SURE THAT YOUR APPLICATION INCLUDES ALL OF THE FOLLOWING
INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED**

| |
|--|
| <input type="checkbox"/> A current photograph |
| <input type="checkbox"/> Current Curriculum Vitae |
| <input type="checkbox"/> Copy of all training contracts to date, i.e. internship, all residency years |
| <input type="checkbox"/> A TYPED personal statement |
| <input type="checkbox"/> Original medical school transcripts sent directly from sending institution |
| <input type="checkbox"/> Original undergraduate transcripts sent directly from sending institution |
| <input type="checkbox"/> A copy of your Medical School Diploma |
| <input type="checkbox"/> Copies of any / all applicable licensure/ permits |
| <input type="checkbox"/> Copy of current ACLS |
| <input type="checkbox"/> Copy of current BLS |
| <input type="checkbox"/> COMLEX score reports (official / not computer generated) |
| <input type="checkbox"/> Three (3) letters of recommendation current within 90 days sent directly to this program from the sender Note: One letter of recommendation must be from your Internal Medicine Residency Program Director |
| <input type="checkbox"/> Medical school deans letter |
| <input type="checkbox"/> Other documentation as may be listed / required on your application |
| <input type="checkbox"/> Most recent milestones |
| <input checked="" type="checkbox"/> Application |

**ALL APPLICATIONS MUST BE SENT VIA MAIL TO:
JEFFERSON HEALTH NJ – VIRTUA OLOL
CARDIOLOGY FELLOWSHIP
KELLY BROOME
1 BRACE ROAD, SUITE C
CHERRY HILL, NEW JERSEY 08034
NO EMAIL OR FAXED APPLICATIONS WILL BE ACCEPTED**

Dear Doctor:

Attached is an application for residency and fellowship programs. This application is used for the Cardiology Fellowship Program at Jefferson Health NJ - Virtua Our Lady of Lourdes.

Please submit all information to the appropriate Program Director's office. Names, addresses, and phone numbers for residency and fellowship Program Directors are on the accompanying pages. Please check with the program for deadline dates and available positions. To be considered for a residency or fellowship program, please send the following to the Program Director's office as soon as possible:

1. Completed application (typed or printed legibly in black ink)
2. Official medical school transcript
3. Part I, II, and III Board scores
4. Three (3) current letters of recommendation
5. Copy of contract from internship year
6. Copy of internship and/or residency certificates
7. Copy of any state license (if applicable)
8. Copy of the CDS and DEA certifications
9. Certificates of Postgraduate Training (Blank copies can be obtained through the GME Office at Virtua Rowan-SOM and must be completed by all prior training programs.)
10. Most recent milestones

Should you have any questions, please call the Program Director's Assistant at the number listed on the accompanying pages.

Sincerely,

Richard Paluzzi, M.D.
Virtua Medical Director of Medical Education

Victoria Hanlon, MS, CHCP
Corporate Director, GME Strategy & Integration Jefferson Health New Jersey

APPLICATION FOR CARDIOLOGY FELLOWSHIP TRAINING

Jefferson Health NJ -

Virtua Our Lady of Lourdes (VOLOL)

Application for Fellowship in _____

For Osteopathic Graduate Medical Education Year (i.e., OGME 4, 5) _____ beginning July, _____

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK.

Name _____
(Last) (First) (Middle)

Social Security No. _____ AOA No. _____

Present Address _____ Phone (_____) _____
_____ Zip _____

Permanent Address _____ Phone (_____) _____
_____ Zip _____

Check preferred mailing address as listed above: _____ Present Address _____ Permanent Address

Phone where you can be reached during the day: (_____) _____

E-Mail Address _____

Emergency Contact _____

Address _____

Phone: Day (_____) _____ Night (_____) _____

Are you a: _____ U.S. Citizen? _____ Permanent Resident? _____ Other?*

*If other, please provide documentation for eligibility to be employed in the U.S.

References: List the names, titles and addresses of three references.

1. _____

2. _____

3. _____

Pre-Professional Education: List, in order, Colleges or Universities you have attended.

| <u>Name of College</u> | <u>Location</u> | <u>Dates of Attendance</u> | <u>Degree and Date</u> |
|------------------------|-----------------|----------------------------|------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Professional Education: List medical school(s) you attended.

| <u>Name of Medical School</u> | <u>Location</u> | <u>Dates of Attendance</u> | <u>Degree and Date</u> |
|-------------------------------|-----------------|----------------------------|------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Post-Graduate Education:

Internship: Track _____ Dates ____/____/____ to ____/____/____
Institution _____ City: _____ State: _____
Residency: Specialty _____ Dates ____/____/____ to ____/____/____
Institution _____ City: _____ State: _____

Hospital Affiliations: List Hospital names, locations and dates of Hospital staff appointments.

Present Membership in Organizations: List professional, scientific, etc.

Research or Practical Experience: Include Publications, if any.

National Board of Osteopathic Medical Examiners board scores (COMLEX):

Part I _____ Date of Examination _____
Part II _____ Date of Examination _____
Part III _____ Date of Examination _____
Do you plan on taking the USMLE? _____No _____Yes, Date of Exam _____

New Jersey License Number _____

Please attach copy of New Jersey license.

Has your New Jersey license ever been suspended or revoked?

Yes _____ No _____

If yes, please explain: _____

New Jersey CDS Number _____

Has your New Jersey CDS certificate ever been suspended or revoked?

Yes _____ No _____

If yes, please explain: _____

Federal DEA Registration Number _____

Has your Federal DEA certificate ever been suspended or revoked?

Yes _____ No _____

If yes, please explain: _____

Do you have a license to practice medicine in any other state(s)?

Yes _____ No _____

If yes, list states, dates and license numbers.

| <u>State</u> | <u>Dates</u> | <u>License Number</u> |
|--------------|--------------|-----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have you ever been involved in a malpractice suit?

Yes _____ No _____

If yes, please give the date and nature of case(s) and status of the suit, i.e., open, dismissed, closed with payment.

| <u>Date</u> | <u>Nature of Case</u> |
|-------------|-----------------------|
| _____ | _____ |
| _____ | _____ |

Discuss your plans after you finish your residency/fellowship program. Include practice location, if known.

Please use the space below to amplify upon your biographic data with any information that you think would be helpful in the evaluation of your application.

The Virtua Graduate Medical Education Office is the only authorized person who can offer letters of acceptance or contracts to any of our residency or fellowship programs. Any other offer letters or contracts will not be recognized by the Jefferson Health NJ – Virtua Our Lady of Lourdes or any of its affiliated programs or hospitals.

Your signature below indicates that you have completed this application in good faith and all answers are complete and honest. You also understand that no one other than Virtua Graduate Medical Education at Jefferson Health NJ – Virtua Our Lady of Lourdes is authorized to make offers of acceptance or issue contracts to our programs.

(Applicant's Signature)

(Date)

(Print Name)

Jefferson Health NJ - Virtua Our Lady of Lourdes does not discriminate in admissions or access to its programs and activities on the basis of race/color, national origin, ethnicity, religion/creed, disability, age, marital status, sex, sexual orientation or veteran's status.

Appointment to this position requires that you are not listed by the Office of Inspector General (OIG) and/or the General Services Administration (GSA) as excluded from participating in federal health care, research, or other grant programs.

Jefferson Health NJ -

Virtua Our Lady of Lourdes (VOLOL)

AUTHORIZATION FOR RELEASE OF INFORMATION AND

RELEASE FROM CIVIL LIABILITY

I specifically authorize the Institution and its authorized representatives to consult with the management and members of the medical staffs of other hospitals, health care facilities, previous colleges/universities and/or other institutions with which I have been associated and with others who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter. This Institution or its authorized representatives may inquire and inspect all records and documents that may be material to the above.

I hereby release from civil liability any individual or institution reviewing or providing information relative to my application for fellowship at Jefferson Health NJ – Virtua OLOL.

(Applicant's Signature)

(Date)

(Print Name)