

LIMB PRESERVATION, WOUND CARE, and DIABETIC LOWER EXTREMITY COMPLICATIONS FELLOWSHIP APPLICATION



DEPARTMENT OF INTERNAL MEDICINE
Metabolism, Endocrinology & Diabetes - Podiatry
Domino Farms (Lobby C, Suite 1300)
24 Frank Lloyd Wright Drive
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[Visit our website](#)

PLEASE FOLLOW ALL INSTRUCTIONS AS OUTLINED BELOW.

APPLICATION DEADLINE FOR THE 2025-2026 FELLOWSHIP TRAINING YEAR: **OCTOBER 1, 2024**

THE FOLLOWING MATERIALS MUST BE INCLUDED AND SUBMITTED TOGETHER AS ONE PACKET:

- Signed and Completed Application
- CV
- Medical School Transcript
- Letter of Intent/Personal Statement
- 3 Letters of Reference (signed, dated, on letterhead, and one must be current program director and our program director may contact your current director)

Instructions: Please provide the information requested in this application. Your application will not be processed or considered unless all information requested is received. Submit application, application information, letters, CV, and transcript to marrhode@med.umich.edu.

Where did you hear about our fellowship:

APPLICANT DEMOGRAPHICS:

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____ CITIZENSHIP: _____

DRIVER'S LICENSE NO: _____ ISSUE STATE/DATE: _____ EXPIRATION: _____

HOME ADDRESS: _____ PHONE: _____

WORK ADDRESS: _____ PHONE: _____

EMAIL ADDRESS: _____ FAX: _____

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APPLICANT EDUCATION (*Please record all dates attended in MM/YYYY format, including anticipated completion of your residency training):

UNDERGRADUATE INSTITUTION: _____ DEGREE: _____

LOCATION: _____ DATES ATTENDED*: _____

GRADUATE INSTITUTION: _____ DEGREE: _____

LOCATION: _____ DATES ATTENDED*: _____

PODIATRIC MEDICAL SCHOOL: _____ DEGREE: _____

LOCATION: _____ DATES ATTENDED*: _____

POST-GRADUATE TRAINING:

RESIDENCY: _____

LOCATION: _____ DATES ATTENDED*: _____

PROGRAM DIRECTOR: _____

RESIDENCY: _____

LOCATION: _____ DATES ATTENDED*: _____

PROGRAM DIRECTOR: _____

NBPME EXAMINATIONS (Please record date (MM/YYYY) each section was passed):

NBPME Part 1: _____ NBPME Part 2: _____ PART 2 WRITTEN: _____ CSPE: _____

Please explain any gaps in your training: _____

MEDICAL LICENSES:

STATE: _____ NUMBER: _____ ISSUE DATE: _____ EXP DATE: _____

STATE: _____ NUMBER: _____ ISSUE DATE: _____ EXP DATE: _____

STATE: _____ NUMBER: _____ ISSUE DATE: _____ EXP DATE: _____

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REFERENCES:

NAME: _____

WORK ADDRESS: _____

PHONE: _____

E-MAIL ADDRESS: _____

NAME: _____

WORK ADDRESS: _____

PHONE: _____

E-MAIL ADDRESS: _____

NAME: _____

WORK ADDRESS: _____

PHONE: _____

E-MAIL ADDRESS: _____

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LEGAL HISTORY:

Has a medical malpractice claim/judgment ever been filed/entered against you, or is a claim against you settled or pending?

- YES NO

If yes, then please explain thoroughly below:

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Why did you decide to apply for the University of Michigan Podiatry Fellowship Program?

I hereby certify that the information provided in this application is true and accurate.

PRINT NAME

SIGNATURE

DATE

**PLEASE FORWARD ALL APPLICATION MATERIALS TO MARRHODE@MED.UMICH.EDU
BY OCTOBER 1, 2024.**