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

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

DEPARTMENT OF INTERNAL MEDICINE
Metabolism, Endocrinology & Diabetes - Podiatry
Domino Farms (Lobby C, Suite 1300)
24 Frank Lloyd Wright Drive
Ann Arbor, MI 48106-0451
Phone: (734) 647-5871
Fax: (734) 647-2145
Visit our website

**PLEASE FOLLOW ALL INSTRUCTIONS AS OUTLINED BELOW.**

**APPLICATION DEADLINE FOR THE 2025-2026 FELLOWSHIP TRAINING YEAR: JANUARY 27, 2025**

**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 JANUARY 27, 2025.**