

**Klinikum Großhadern**  
**Ludwig Maximilian University Munich (LMU)**  
Director: Prof. Dr. Dr. h.c. K. Peter  
Marchioninstr. 15  
81377 München  
Germany

## Application Form for Postgraduate Fellowship Program

Training in the LMU University Clinic  
according to federal accreditation board of the State of Bavaria

**Type of Fellowship:** \_\_\_\_\_

(all materials sent as part of this application process will be retained by the Fellowship Committee and will not be returned to the applicant). All information should be completed in English and should be typed.

Please contact the LMU Munich Medical International Fellowship Coordinator at Marchioninstr. 15, D-81377 München, Germany; Phone: +49-(0) 89-7095-3416, Fax: +49-(0) 89-7402-9548; E-Mail: [info@lmu-mmi.de](mailto:info@lmu-mmi.de) if you have questions.

### I. PERSONAL DATA

**1. Name in full:** \_\_\_\_\_  
(first) (middle) (last)

\_\_\_\_\_  
(previous last name, if applicable)

**2. Home address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. Present address (if different):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. Telephone Number (Work):** \_\_\_\_\_ (Home): \_\_\_\_\_

**5. Page telephone number and beeper number:** \_\_\_\_\_

**6. Fax Number:** \_\_\_\_\_

7. E-mail address: \_\_\_\_\_

8. Marital status:       single               married               divorced               widowed

9. Gender:               Female               Male

10. Date of Birth (MM/DD/YY): \_\_\_\_\_

11. In case of emergency, notify:

Name: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

12. Spoken Languages: \_\_\_\_\_

13. Citizenship: \_\_\_\_\_

14. Place of Birth: \_\_\_\_\_

15. Passport Number: \_\_\_\_\_

16. Do you have any disabilities or limitations that would prevent you from performing the responsibilities of this fellowship (including certified cognitive disabilities)?

No                       Yes (please explain)

17. Will you need assistance or special accommodations to carry out the responsibilities of a fellow in the specialties and at the specific training programs to which you are applying including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements?

No                       Yes (please explain)

18. Do you have military or other such service obligations?

No                       Yes (if yes, please explain)

**19. Have you been charged with a criminal offense?**

No  Yes (if yes, please explain)

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**20. Have you been treated for substance abuse?**

No  Yes (if yes, please explain)

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**II. EDUCATION, CERTIFICATION, LICENSURE, AND EXPERIENCE**

**1. For each institution you have attended, please provide the information requested below:**

**A. Secondary School:**

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Graduation date: \_\_\_\_\_

Degree: \_\_\_\_\_

**B. College or University Education (Bachelor or Associate degree):**

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Graduation date: \_\_\_\_\_

Major: \_\_\_\_\_

Degree: \_\_\_\_\_

**C. Postgraduate or University Education (Masters or Doctorate):**

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Graduation date: \_\_\_\_\_

Degree: \_\_\_\_\_

Area of concentration: \_\_\_\_\_

**D. Medical School or University (Medical Degree):**

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Graduation date: \_\_\_\_\_

Degree: \_\_\_\_\_

Was your medical education extended or interrupted?

No

Yes (if yes, please explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please use this space to list any honors or awards received while in training or during your career:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**E. Residency and Internship Training (please list most recent first):**

**1.**

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Dates: \_\_\_\_\_

Completion date: \_\_\_\_\_

Type (e.g. pediatrics): \_\_\_\_\_

Board certified?  Yes  No

Name of Board or Professional College: \_\_\_\_\_

Country of Certification: \_\_\_\_\_

Date: \_\_\_\_\_

Certificate No.: \_\_\_\_\_

**2.**

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Dates: \_\_\_\_\_

Completion date: \_\_\_\_\_

Type (e.g. pediatrics): \_\_\_\_\_

Board certified?  Yes  No

Name of Board or Professional College: \_\_\_\_\_

Country of Certification: \_\_\_\_\_

Date: \_\_\_\_\_

Certificate No.: \_\_\_\_\_

**3.**

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Dates: \_\_\_\_\_

Completion date: \_\_\_\_\_

Type (e.g. pediatrics): \_\_\_\_\_

Board certified?  Yes  No

Name of Board or Professional College: \_\_\_\_\_

Country of Certification: \_\_\_\_\_

Date: \_\_\_\_\_

Certificate No.: \_\_\_\_\_

**F. Relevant work experience, if applicable (please list most recent first):**

**1.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

**3.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**G. Volunteer Experience, if applicable (please list most recent first):**

**1.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

\_\_\_\_\_

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**3.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

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**1. Have your privileges at any hospital or other facility ever been denied, limited, suspended, revoked, or not renewed? And/or have you ever been denied membership or a renewal therein or been subjected to disciplinary proceedings in any hospital or medical organization?**

No  Yes (If yes, please give full details on separate sheet)

**2. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?**

No  Yes (If yes, please give full details on separate sheet)

**3. Have you ever voluntarily relinquished your license?**

No  Yes (If yes, please give full details on separate sheet)

**4. Have you been named as a defendant in a malpractice case?**

No  Yes (If yes, please provide details on type of case and outcome on a separate sheet)

**5. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?**

No  Yes (If yes, please provide full details on a separate sheet)

**6. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?**

No  Yes (If yes, please provide full details on a separate sheet)

**7. Please list all jurisdictions in which you have a license to practice medicine. If more than two, please list on a separate sheet.**

**a)**

Jurisdiction: \_\_\_\_\_ Country: \_\_\_\_\_

License or Ministry Staff Number: \_\_\_\_\_

Effective dates: \_\_\_\_\_

**b)**

Jurisdiction: \_\_\_\_\_ Country: \_\_\_\_\_

License or Ministry Staff Number: \_\_\_\_\_

Effective dates: \_\_\_\_\_

**8. Have you passed the United States Medical Licensing Exam(s) (USMLE)?**

No

Yes (If yes, please list scores below and enclose copy of certificate)

Step 1 Date: \_\_\_\_\_ Score: \_\_\_\_\_

Step 2 Date: \_\_\_\_\_ Score: \_\_\_\_\_

**9. Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?**

No

Yes (If yes, please list certificate number below and enclose copy of certificate)

Month: \_\_\_\_\_ Year: \_\_\_\_\_ Standard Certificate\* No.: \_\_\_\_\_

**10. Are you ACLS (Advanced Cardiac Life Support) certified?**

No

Yes (If yes, please indicate expiration date below and enclose copy of certificate)

Expiration date: \_\_\_\_\_

**11. Are you PALS (Pediatric Advanced Life Support) certified?**

No

Yes (If yes, please indicate expiration date below and enclose copy of certificate)

Expiration date: \_\_\_\_\_

**12. Are you subject to Continuing Medical Education (CME) requirements?**

No

Yes

If you answered yes to #12, have you fulfilled your CME requirements? Please explain.

\_\_\_\_\_

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### III. ENGLISH AND GERMAN COMPETENCY

#### 1. English competency:

**A. Have you passed the English competency exam?**

No  Yes (If yes, please indicate TOEFL exam information below)  
TOEFL Date: \_\_\_\_\_ Level: \_\_\_\_\_

**B. Did you attend an English language medical school, university or training program?**

No  Yes (If yes, please complete)  
Institution: \_\_\_\_\_ Country: \_\_\_\_\_  
Dates (MM/DD/YY-MM/DD/YY): \_\_\_\_\_

**C. Have you completed a Residency/Fellowship Program in an English speaking country?**

No  Yes (If yes, please complete)  
Institution: \_\_\_\_\_ Country: \_\_\_\_\_  
Dates (MM/DD/YY-MM/DD/YY): \_\_\_\_\_

**D. English language references for 1B or 1C:**

I. \_\_\_\_\_  
II. \_\_\_\_\_  
III. \_\_\_\_\_

#### 2. German competency:

**A. Have you passed a German competency exam?**

No  Yes (If yes, please indicate TestDaF or ZD exam information below)  
TestDaF Date: \_\_\_\_\_ Level: \_\_\_\_\_  
ZD Date: \_\_\_\_\_ Level: \_\_\_\_\_

**B. Did you attend a German language medical school, university or training program?**

No  Yes (If yes, please complete)  
Institution: \_\_\_\_\_ Country: \_\_\_\_\_  
Dates (MM/DD/YY-MM/DD/YY): \_\_\_\_\_

**C. Have you completed a Residency/Fellowship Program in Germany?**

No

Yes (If yes, please complete)

Institution: \_\_\_\_\_ Country: \_\_\_\_\_

Dates (MM/DD/YY-MM/DD/YY): \_\_\_\_\_

**D. German language references for 1B or 1C:**

I. \_\_\_\_\_

II. \_\_\_\_\_

III. \_\_\_\_\_

**IV. RESEARCH EXPERIENCE AND CAREER PLANS**

**1. Research experience, if applicable (list most recent first):**

**A.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of research: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**B.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of research: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**C.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of research: \_\_\_\_\_

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**2. Do you plan to take further subspecialty fellowships in the future?**

No                       Yes      (If yes, please specify):

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**3. Do you plan to earn any further degrees in the future?**

No                       Yes      (If yes, please specify):

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The placement committee will use questions 4-8 below and your personal statement to customize programs for qualified candidates.

**4. Why are you interested in this Fellowship/Observership Program?**

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**8. If you have published, please list your publications (articles, books, and/or monographs). Please indicate the single publication which represented your best work by listing it first. You may attach a list of your publications if one is available. Abstracts and publications should be separated.**

**A.**

Title: \_\_\_\_\_

\_\_\_\_\_

Authors/presenters: \_\_\_\_\_

\_\_\_\_\_

Publication: \_\_\_\_\_

Month/Year: \_\_\_\_\_

Volume: \_\_\_\_\_

Pages: \_\_\_\_\_

**B.**

Title: \_\_\_\_\_

\_\_\_\_\_

Authors/presenters: \_\_\_\_\_

\_\_\_\_\_

Publication: \_\_\_\_\_

Month/Year: \_\_\_\_\_

Volume: \_\_\_\_\_

Pages: \_\_\_\_\_

**C.**

Title: \_\_\_\_\_

\_\_\_\_\_

Authors/presenters: \_\_\_\_\_

\_\_\_\_\_

Publication: \_\_\_\_\_

Month/Year: \_\_\_\_\_

Volume: \_\_\_\_\_

Pages: \_\_\_\_\_



## VI. REFERENCES

Please arrange to have three letters of reference submitted. If applicant is still in training: written recommendation from medical school or university dean and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant. If applicant has completed training: written recommendation from residency training program director(s) or graduate study supervisor and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant.

Letters should be sent directly to: LMU Munich Medical International GmbH, Schillerstr. 53, D-80336 Munich, Germany, in an envelope with the author's signature across the seal. Letters that are not written in English or German should be accompanied by a certified translation of that letter.

Please list the three referring faculty members from whom we can expect to receive letters of reference on your behalf:

1.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relation to applicant: \_\_\_\_\_

2.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relation to applicant: \_\_\_\_\_

3.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relation to applicant: \_\_\_\_\_

+++++  
I attest that the information included in this application is true to the best of my knowledge.

\_\_\_\_\_  
(Applicant Signature)

\_\_\_\_\_  
(Date)

Please submit completed application form with supporting documentation along with:

- Curriculum Vitae
- Copy of passport
- Copy of qualification to study medicine (final High School report, copy of entry exam)
- Certified copy of medical school diploma (for clinical fellowships only)
- Certified copy of university diploma (for research fellowships only)
- Certified copy of residency certificate (for clinical fellowships only)
- Certified copy of fellowship certificate (if applicable)
- Proof Medical Liability cover for Germany
- Official or official certified copy of transcript (in English) from medical school (for clinical fellowships only)
- Proof of health insurance cover for Germany

If any document has been translated into English, please send the original document along with the certified translation of that document.

**Send completed application and enclosures to:**

**LMU Munich Medical International  
Fellowship Coordinator  
Schillerstr. 53  
D-80336 München  
Germany**