Hartford HealthCare Headache Center
Headache and Facial Pain Fellowship Application

CONTACT INFORMATION:

Name (first and last)**:** _____

Email Address: _____

Phone Number: _____

Mailing Address (line 1)**:** _____

(line 2)**:** _____

City, State, Zip Code: _____

Degree: _____

Citizenship: _____

J-1 Visa: ❑ No ❑ Yes – include a copy of your visa with your application

CURRENT / PRIOR GME TRAINING:

Discipline: _____

Institution & Location: _____

Dates Attended: _____

Discipline: _____

Institution & Location: _____

Dates Attended: _____

MEDICAL EDUCATION:

Medical School: _____ **Year Graduated:** _____

Internship: _____ **Year Graduated:** _____

Residency: _____ **Year Graduated:** _____

***If you are a FMG, please include a copy of your ECFMG certificate**

RECOMMENDATION LETTERS:

Three letters of recommendation are required. These letters must be from faculty members that you have worked with during residency or graduate medical education training.

Please list the faculty who will provide letters of recommendation.

Name	Title	Email Address

Along with the completed application please include:

- Recent Photo
- Curriculum Vitae
- Personal Statement
- Visa (if applicable)
- USMLE Results
- ECFMG Certificate (if applicable)

Email completed application and additional documents to: headachecenter@HHChealth.org