



Physical Medicine & Rehabilitation

Application for Fellowship Traumatic Brain Injury Medicine

UT SOUTHWESTERN MEDICAL CENTER AT DALLAS
5323 Harry Hines Blvd.
Dallas, Texas 75390-9055

Terri Isbell
Residency & Fellowship Coordinator
E-mail: terri.isbell@utsouthwestern.edu
Telefax 214.648.9207

Please Circle Pass or Fail and provide information on the following:

USMLE Step I
PASS Score _____
FAIL Attempts _____

USMLE Step II
PASS Score _____
FAIL Attempts _____

USMLE Step III
PASS
FAIL

PROFESSIONAL LICENSES / CERTIFICATIONS

Registered _____

Certified _____

Licensed _____

Type: _____

Date Issued: _____

Expiration Date: _____

Number & State: _____

Registered _____

Certified _____

Licensed _____

Type: _____

Date Issued: _____

Expiration Date: _____

Number & State: _____

Noted Restrictions (circle one)? YES NO

If Yes, please specify:

1. Have any legal claims or lawsuits been filed against you regarding patient care or treatment (circle one)? YES NO
2. Do you have any pending or threatened malpractice claims or lawsuits against you (circle one)? YES NO
3. Have any of the licenses or certifications identified in the previous section ever been revoked (circle one)? YES NO
4. Have you previously had hospital staff or other medical privileges revoked (circle one)? YES NO
5. Have you ever been placed on probation during residency (circle one)? YES NO

If you answered "Yes" to any of the above, please explain below (attach additional explanation if necessary): _____

SERVICE OBLIGATIONS (National Health Service Corps, Armed Forces Scholarship, State Programs, etc.)

_____ I am not required to fulfill any service obligations

_____ I am committed to fulfill a service obligation beginning _____

(MO./YR.)

Number of years committed _____

ACKNOWLEDGEMENT:

I ACKNOWLEDGE THE ABOVE ANSWERS AND ALL OTHER INFORMATION OTHERWISE GIVEN BY ME AS BEING TRUE, COMPLETE, AND NOT MISLEADING IN ANY WAY. I UNDERSTAND THAT ANY FALSE, INCOMPLETE, OR INCORRECT STATEMENTS FURNISHED BY ME CAN RESULT IN DISCHARGE. I AGREE TO COMPLY WITH ALL THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS REGULATIONS AND/OR POLICIES. I UNDERSTAND THAT UT SOUTHWESTERN MAY TERMINATE MY EMPLOYMENT AT ANY TIME FOR ANY REASON PURSUANT TO APPLICABLE POLICIES AND PROCEDURES OF THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS.

Signature of Applicant: _____

Date: _____

PLEASE INCLUDE THE FOLLOWING WITH THIS APPLICATION:

- **3 LETTERS OF RECOMMENDATION FROM YOUR CURRENT PROGRAM AND INTERNSHIP YEAR**
 - Letters of recommendation **MUST** be addressed to Samuel Bierner, M.D. and sent directly to Terri Isbell by the author of the letter.
- **ORIGINAL MEDICAL SCHOOL TRANSCRIPTS**
- **USMLE TRANSCRIPTS**
- **COPY OF ALL STATE MEDICAL LICENSES CURRENTLY HELD**
- **COPY OF DEA REGISTRATION, TEXAS DPS REGISTRATION**
- **PERSONAL STATEMENT**

Please remit entire application and attachments to:

Terri Isbell
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UT Southwestern Medical Center at Dallas
5323 Harry Hines Blvd.
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