



Space Medicine Fellowship

Department of Emergency Medicine

APPLICANT INFORMATION

Last Name:

First Name:

Mailing Address:

City:

State / Country:

Zip Code:

Phone Number:

Date of Birth:

EDUCATION

Undergraduate / College:

Degree / Major:

Year of Graduation

Post-Graduation (If Applicable):

Degree / Major:

Year of
Graduation

Medical School:

Degree (MD, DO) / Major:

Year of
Graduation

Residency Program:

Year of
Graduation

Fellowship (If Applicable)

Year of
Graduation

SUPPORTING DOCUMENTS

Personal statement (3 Pages Maximum)

Curriculum Vitae (CV)

(3) Reference Letters (1 Must Be From Program Director or Current Medical Director if Graduated)

Copies of USMLE / COMLEX Scores 1 & 2

Transcripts from Undergraduate, Graduate, & Medical School

Copy of Residency Certificate (Or Letter of Intent)

Copy of ECFMG Certificate (If Applicable)

PLEASE EMAIL APPLICATION TO:

SPACEMEDICINE@UTH.TMC.EDU

FOR ANY QUESTIONS, PLEASE CALL (713) 500-7878 OR EMAIL **SPACEMEDICINE@UTH.TMC.EDU**
