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)
- ☐ 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**