Glaucoma Research Center Research Fellow Application



This application for	m must he cor	mpleted in English			America's First World	d's Best
This application form Date: Name: Permanent Address: State/Province:	m must be cor	mpleted in English			Wills Glaucoma Rese 840 W Phila Phone: (21 Fax: (21	Eye Hospital
Zip/Postal Code:						
Country:						
Phone #:					I will be invited for a pho se indicate a phone # w	
Email Address:				can be reached		,
Citizenship:	US Citi z	zen				
	Other. Ple	ease specify:				
Type of Fellowship Des Dates of Appointment Education						
Type of School		Name of School, City & Country		Years Attended	Degree	
Undergraduate School						
Medical School						
Internship						
Ophthalmology Residency	,					
Fellowship (if applicable)						
Other Professional Experien	nce					
Other Professional Experien	nce					
Other Professional Experien	nce					
Academic Honor						
Academic Honor	rs, Schola	rships, Publica	tions			
Academic Honor	rs, Schola	rships, Publica	tions			
Academic Honor	rs, Schola	rships, Publica	tions			

Medical Licensure

State & Country:	Date of	
License #:	Issue:	

Personal Statement

In your personal statement, please answer the following questions:

- 1) Why you wish to come to Wills Eye Hospital Glaucoma Research Center?
- 2) What personal and professional and professional outcomes do you anticipate from an experience as a research fellow at the Wills Eye Hospital Glaucoma Research Center?

Please limit your personal statement to 500 words or less. Statements with more than 500 words will be penalized.

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Electronic Signature	Date	

Please complete and send this completed application form with an electronic copy of your CV and recent passport sized photo (2 in x 2 in) to Mary Jo Schwartz at mschwartz@willseye.org.

Mailed paper forms and documents are not accepted. All documents must be in English. If you have any questions, please contact Mary Jo Schwartz.