

**APPLICATION FOR FELLOWSHIP TRAINING  
NUTRITION**

University of Colorado Health Sciences Center  
4200 East Ninth Avenue  
Campus Box C-225  
Denver, CO 80262

Full Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

Permanent Address (if different): \_\_\_\_\_

Day Phone #: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Citizenship: \_\_\_\_\_

VISA Status: \_\_\_\_\_

**EDUCATION EXPERIENCE:**

Undergraduate Degree: \_\_\_\_\_

Institution: \_\_\_\_\_

Year: \_\_\_\_\_

MEDICAL DEGREE: \_\_\_\_\_ DOCTORAL DEGREE: \_\_\_\_\_ (check which apply)

Institution: \_\_\_\_\_

Year: \_\_\_\_\_

OTHER POST-GRADUATE DEGREES: \_\_\_\_\_

Institution: \_\_\_\_\_

Year: \_\_\_\_\_

FOR M.D. APPLICANTS ONLY

**MEDICAL TRAINING**

Internship type: \_\_\_\_\_

Institution: \_\_\_\_\_

Year: \_\_\_\_\_

Residency type: \_\_\_\_\_

Institution: \_\_\_\_\_

Year: \_\_\_\_\_

Institution: \_\_\_\_\_

Year: \_\_\_\_\_

Institution: \_\_\_\_\_

Year: \_\_\_\_\_

M.D.s

Board Certification: \_\_\_\_\_ Certificate #: \_\_\_\_\_ Date: \_\_\_\_\_

FELLOWSHIP APPLICATION

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FOR Ph.D. APPLICANTS ONLY

POST-DOCTORAL TRAINING TO DATE (if applicable)

Area of research: \_\_\_\_\_

Institution and Mentor: \_\_\_\_\_

Year(s): \_\_\_\_\_

List any additional activities since graduate school, including sabbaticals:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Membership of Medical and/or Professional Associations:

\_\_\_\_\_  
\_\_\_\_\_

Special training not listed above: (assistantships, practice, etc): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Publications and Research: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

TO COMPLETE YOUR APPLICATION:

1. Please attach a copy of your personal statement regarding your interests in Nutrition and your professional plans following training. Describe any current or past experience in research and in clinical activities relevant to Nutrition.
2. Please attach a copy of your updated curriculum vitae.
3. Please list below the name, title and address of three individuals who will be providing letters of reference for you. One of these individuals should be the program director of your current (or most recent) training program. We will not contact individuals listed. Please have these individuals send their letters to:

**Tracy Horton, PhD, Assistant Director  
Pediatrics/Section of Nutrition  
University of Colorado Health Sciences Center  
4200 East Ninth Avenue, Campus Box C-225  
Denver, CO 80262  
Tel: (303) 315-3048**

Name/Title: \_\_\_\_\_  
Address: \_\_\_\_\_

Name/Title: \_\_\_\_\_  
Address: \_\_\_\_\_

Name/Title: \_\_\_\_\_  
Address: \_\_\_\_\_