



SUSAN B. MEISTER

CHILD HEALTH EVALUATION AND RESEARCH CENTER

MICHIGAN MEDICINE

CHEAR Fellowship Application

A. Contact information

Name Click or tap here to enter text.
Email address Click or tap here to enter text.
Address Street Click or tap here to enter text. City Click or tap here to enter text. State Click or tap here to enter text. Zip Click or tap here to enter text.
Phone number Click or tap here to enter text.

B. Applicant type and information

Preferred fellowship start date <input type="checkbox"/> July <input type="checkbox"/> September Year: Click or tap here to enter text.
Preferred fellowship end date Month / Year: Click or tap here to enter text.
Position (complete only one of the following) <input type="checkbox"/> Third-year pediatrics resident applying for UM pediatric subspecialty fellowship Name of residency Click or tap here to enter text. Which UM subspecialty fellowship are you applying for? Click or tap here to enter text. Anticipated completion date for residency: Click or tap here to enter text.
<input type="checkbox"/> Current first-year UM pediatric subspecialty fellow Which UM subspecialty fellowship are you currently enrolled in? Click or tap here to enter text.
<input type="checkbox"/> Pediatrician who has completed residency and is applying for UM pediatric subspecialty fellowship Which UM subspecialty fellowship are you applying for? Click or tap here to enter text.
<input type="checkbox"/> Doctoral candidate applying for postdoctoral fellowship Institution Click or tap here to enter text. Concentration (e.g., health policy, economics) Click or tap here to enter text. Anticipated doctoral degree type (e.g., PhD, ScD) Click or tap here to enter text. Anticipated completion date for doctoral degree Click or tap here to enter text.
<input type="checkbox"/> Current doctoral degree holder applying for postdoctoral fellowship Current position Click or tap here to enter text.
<input type="checkbox"/> Joint applicant for UM Pediatric Psychology fellowship Current position Click or tap here to enter text.
<input type="checkbox"/> Other Provide explanation Click or tap here to enter text.

C. Support requested



SUSAN B. MEISTER

CHILD HEALTH EVALUATION AND RESEARCH CENTER
MICHIGAN MEDICINE

Type of support required

☐ Stipend ☐ Tuition ☐ Research mentorship only



SUSAN B. MEISTER

CHILD HEALTH EVALUATION AND RESEARCH CENTER
MICHIGAN MEDICINE

D. Reference contact information

Reference #1

Name Click or tap here to enter text.
Email address Click or tap here to enter text.
Address Street Click or tap here to enter text. City Click or tap here to enter text. State Click or tap here to enter text. Zip Click or tap here to enter text.
Phone number Click or tap here to enter text.

Reference #2

Name Click or tap here to enter text.
Email address Click or tap here to enter text.
Address Street Click or tap here to enter text. City Click or tap here to enter text. State Click or tap here to enter text. Zip Click or tap here to enter text.
Phone number Click or tap here to enter text.