4b

Department of ________________________________

Review Sheet

For Voting Departmental Faculty Use Only

Name:____

Undergraduate School:________________________________

Degree/Date:________________________________

Medical or Graduate School:________________________________

Degree/Date:________________________________

Internship/Field:________________________________

Hospital/Dates:________________________________

Residency/Field:________________________________

Hospital/Dates:________________________________

Fellowship/Field:________________________________

Hospital/Dates:________________________________

Board Certification/Date:________________________________

Subspecialty Certification/Date:________________________________

Positions Held Since Completion of Training:

Institution	Title	Dates

(To be sent with form 4a to departmental voting faculty)