

University of Tennessee Health Science Center  
**Boling Center for Developmental Disabilities (BCDD)**  
*Tennessee's University Center for Excellence in Developmental Disabilities,  
Education, Research, and Service (UCEDD)  
Maternal and Child Health Bureau LEND Project*  
711 Jefferson Avenue Memphis, TN 38105  
(901) 448-6511 Fax: (901) 448-7097  
E-mail: [rrobert8@utmem.edu](mailto:rrobert8@utmem.edu)

**APPLICATION FOR FELLOWSHIP OR TRAINEESHIP**  
**(Please print or type)**

**LETTER OF APPLICATION:**

Return this completed application or a curriculum vitae with the required information with a letter stating why you seek this training. Include a statement of your training goals at the Boling Center for Developmental Disabilities and your career goals.

**LETTERS OF REFERENCE:**

Request letters of reference from two persons who can attest to personal and professional knowledge of you, for example a major professor, departmental chair, or a current employer. Letters should be directly sent from these persons to Training Coordinator at the Boling Center for Developmental Disabilities.

**TRANSCRIPTS:**

An official copy of your transcript(s) should be sent directly from each of your degree granting institutions to: Training Coordinator at the Boling Center for Developmental Disabilities.

Date \_\_\_\_\_

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Ethnic Identity \_\_\_\_\_

Place of Birth \_\_\_\_\_ U.S. Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Permanent Resident Visa? Yes \_\_\_\_\_ No \_\_\_\_\_

Permanent Address \_\_\_\_\_

Permanent Phone: \_\_\_\_\_

Current Mailing Address \_\_\_\_\_

Day phone ( ) \_\_\_\_\_ Evening phone ( ) \_\_\_\_\_

E-mail \_\_\_\_\_

**TYPE OF TRAINING DESIRED:**

Discipline \_\_\_\_\_ Number of months of training requested \_\_\_\_\_

Hours per week \_\_\_\_\_ Types of experience desired \_\_\_\_\_

Preferred dates of training \_\_\_\_\_

Is this training a degree requirement? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what institution \_\_\_\_\_

Have you had training in HIPAA privacy provisions? Yes \_\_\_\_\_ No \_\_\_\_\_

**PRIOR EDUCATION:**

**A. Undergraduate Institution (include address)**

\_\_\_\_\_  
Major \_\_\_\_\_ Degree \_\_\_\_\_ Date of Graduation \_\_\_\_\_

**B. Graduate Institution (include address)**

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Major \_\_\_\_\_ Degree \_\_\_\_\_ Date of Graduation \_\_\_\_\_

**C. Graduate Institution (include address)**

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Major \_\_\_\_\_ Degree \_\_\_\_\_ Date of Graduation \_\_\_\_\_

**PROFESSIONAL EXPERIENCE: (most recent first)**

1. Title \_\_\_\_\_ Dates \_\_\_\_\_  
Employer \_\_\_\_\_ Supervisor \_\_\_\_\_  
Address \_\_\_\_\_

2. Title \_\_\_\_\_ Dates \_\_\_\_\_  
Employer \_\_\_\_\_ Supervisor \_\_\_\_\_  
Address \_\_\_\_\_

3. Title \_\_\_\_\_ Dates \_\_\_\_\_  
Employer \_\_\_\_\_ Supervisor \_\_\_\_\_  
Address \_\_\_\_\_

**SCHOLASTIC OR PROFESSIONAL HONORS OR AWARDS:**

**ACTIVITIES, such as Membership in Professional Organizations and Committees:**

**PUBLICATIONS:**