

**APPLICATION FOR CALIFORNIA EPIDEMIOLOGIC INVESTIGATION SERVICE (Cal-EIS) TRAINING**

Please PRINT or TYPE all responses, then sign and date on the next page. In addition, attach a typewritten Statement of Purpose (see item 15) and a curriculum vitae (CV). For items 10-14, if your CV contains the requested information, write “see attached CV” in the blank space(s).

1. NAME: Last	First	Middle
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2. ADDRESS: (Street, City, State, ZIP)
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3. TELEPHONE: Home:  Work:  Cell:  E-mail:	4. ARE YOU A U.S. CITIZEN?  <input type="checkbox"/> Yes <input type="checkbox"/> No	5. IF NON-U.S. CITIZEN, SPECIFY CITIZENSHIP OR TYPE OF VISA
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6. IF YOU HOLD A CALIFORNIA PROFESSIONAL LICENSE (e.g. IN NURSING OR IN VETERINARY MEDICINE), PLEASE GIVE THE FOLLOWING INFORMATION.  LICENSE TYPE: _____  LICENSE NUMBER: _____ EXPIRATION _____
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7. IN WHAT OTHER STATES ARE YOU LICENSED? (INCLUDE DATES)
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8. PLEASE RATE THE FOLLOWING POSSIBLE GEOGRAPHIC LOCATIONS FOR YOUR FELLOWSHIP PLACEMENT USING THIS SCALE: 1. PREFERRED    2. ACCEPTABLE    3. NOT ACCEPTABLE
<input type="checkbox"/> SO. CALIFORNIA <input type="checkbox"/> CENTRAL VALLEY <input type="checkbox"/> SAN FRANCISCO AREA <input type="checkbox"/> SACRAMENTO AREA <input type="checkbox"/> NO. CALIFORNIA

9. EDUCATION, INTERNSHIPS, RESIDENCIES. Have official transcripts of your graduate (post-baccalaureate) education mailed to the program at the address on the next page. Summarize your undergraduate education, graduate education, internships, and residencies here. Attach additional pages if necessary.

NAMES AND LOCATIONS OF SCHOOLS OR INSTITUTIONS ATTENDED	MAJOR	DIPLOMA OR DEGREE	DATE OF COMPLETION

10. EXPERIENCE RECORD: List chronologically all experience in Medicine, Epidemiology, Public Health, or related fields, excluding internship and residencies. The earliest employment should appear first. Attach additional pages if necessary.

DATES		NAME AND ADDRESS OF EMPLOYER	DESCRIPTION OF DUTIES OR POSTION
FROM	TO		

11. MEMBERSHIP IN PROFESSIONAL OR HONORARY ASSOCIATIONS:	12. HONORS, PRIZES, AWARDS:
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13. PUBLICATION(S):

14. REFERENCES: Request that three persons, including at least one health professional in your field, e-mail a Letter of Recommendation to the program at the e-mail below. (For example, if you are a veterinarian, you must have at least one Letter of Recommendation from another veterinarian.) List your references here.

NAME	OCCUPATION AND TITLE	INSTITUTION AND TELEPHONE

15. STATEMENT OF PURPOSE: Please attach a one-page, typewritten statement (one-inch margins, Arial 12-point font) outlining why you want to participate in the Cal-EIS Fellowship Program. Describe your interest in public health, epidemiology, and public service, along with any ties to the state of California. Explain what you hope to obtain from the fellowship experience, your career plans and goals, and any other information which may be helpful to the Advisory Committee. The Advisory Committee considers this to be a crucial part of your application.

16. NOTE: An interview is required before a final decision can be made. After your application has been reviewed, we will notify you if you are eligible for an interview.

NOTICE TO APPLICANTS:

The information requested on this form is required by the State Department of Public Health to determine your eligibility for acceptance into the Department's Cal-EIS program. The information will also be used by the Cal-EIS Advisory Committee to select candidates for inclusion into the training program. Participation in this Fellowship program is voluntary. If you choose to participate, you are required to provide information on these forms. If you do not provide this information, admission into the Fellowship program may be denied.

Any information that you provide may be used by the State Department of Public Health or transferred to the Department of Public Health's Cal-EIS Advisory Committee and institutions formally participating in the training program. Candidates and authorized personnel directly involved in the selection process will be allowed access. If you wish to review these records, contact the Program Coordinator, at the address below. After reviewing your records, you may request in writing that they be corrected or amended to make them accurate, relevant, and complete. Any request for correction or amendment should also be sent to the Program Coordinator.

Authority for this program is found in Health and Safety Code, Section 131085.

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**I certify that the information I have provided in my application is correct, and that I have read the above "Notice to Applicants."**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please mail or e-mail this application form to:

Program Coordinator  
California Department of Public Health  
California Epidemiologic Investigation Service  
MS-7208  
P.O. Box 997377  
Sacramento, CA 95899-7377  
CAL\_EIS@cdph.ca.gov

For FedEx, UPS, or other courier:

Program Coordinator  
California Department of Public Health  
California Epidemiologic Investigation  
Service MS-7208  
1616 Capitol Ave, Suite 74.420  
Sacramento, CA 95814

In addition, please request that official transcripts are sent directly to the appropriate address above. Please e-mail all Letters of Recommendation to CAL\_EIS@cdph.ca.gov. If you have any questions, please contact the Program Coordinator at (916) 552-9929 or e-mail CAL\_EIS@cdph.ca.gov. Thank you.