BROOKS IHL Speech-Language Pathology Clinical Fellowship Program 2027-2028

In addition to full **typed** completion of the information requested below, please include the following:

- *Resume/CV*
- *Copy of Speech-Language Pathology School Transcript*

PLEASE SUBMIT ALL MATERIALS INFO@BROOKSIHL.ORG NO LATER THAN **March 1, 2027 @ 11:59PM:**

3599 University Blvd South
Jacksonville, FL 32216
info@brooksihl.org

Which fellowship are you applying for?

☐ Pediatric Speech Fellowship ☐ Adult Medical Speech Fellowship

PERSONAL DATA

Last Name	First Name
Street Address	City/State/Zip
Primary Phone Number	Primary E-Mail

COLLEGES ATTENDED

Name	Years Attended From-To
Degree Earned	Degree Awarded Date
Name	Years Attended From-To
Degree Earned	Degree Awarded Date
Name	Years Attended From-To
Degree Earned	Degree Awarded Date

Name	Years Attended From-To
Degree Earned	Degree Awarded Date

CONTINUING EDUCATION COURSES

Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed
Name	Organization	Date Completed

EXPERIENCES

PROFESSIONAL EMPLOYMENT HISTORY

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

CLINICAL EXPERIENCES/INTERNSHIPS

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

Position Title	Organization Name	Dates
City, State	Average Hours per Week	Name of Supervisor
May we Contact this Organization	Supervisors E-Mail Address	Supervisors Phone Number

Duties:

ACHIEVEMENTS

Name	Organization	Date
Name	Organization	Date
Name	Organization	Date

LICENSES AND CERTIFICATIONS

Type	State	Number
Type	State	Number
Type	State	Number

CREDENTIALS AND CERTIFICATIONS

Certification/ Credential Type	Issue Organization	Certification Number	Certification Date	Expiration Date
Certification/ Credential Type	Issue Organization	Certification Number	Certification Date	Expiration Date
Certification/ Credential Type	Issue Organization	Certification Number	Certification Date	Expiration Date

MEMBERSHIPS

Name

Name

Name

SUPPLEMENTAL QUESTIONS

What do you wish to gain through participation in a fellowship program?

Discuss aspects of your background and professional experience that particularly qualify you for participation in a fellowship program.

Have you found your professional passion, and if so, what is it? How does the fellowship program fit in your plans for following this passion?

REFERENCES https://bihl.wufoo.com/forms/q1pzlgdp1e5ckf3/

All 3 references must be from licensed Speech-Language Pathologists, with at least one being from a clinical instructor, and another from a Speech-Language Pathology Academician. References should be submitted using the following link: https://bihl.wufoo.com/forms/q1pzlgdp1e5ckf3/

Name	Title
Organization	Occupation
Date	Email Address

Name	Title
Organization	Occupation
Date	Email Address

Name	Title
Organization	Occupation
Date	Email Address

Additional Information:

U.S. Citizen?

☐ YES ☐ NO

VISA Details (if applicable):