

ORTHOPAEDIC SHOULDER/ELBOW FELLOWSHIP APPLICATION

THIS FORM HAS BEEN APPROVED FOR USE BY MOST ORTHOPAEDIC SHOULDER/ELBOW FELLOWSHIP PROGRAMS. IT MAY BE DUPLICATED. APPLICATIONS AND DOCUMENTS SHOULD BE DIRECTED TO THE INDIVIDUAL PROGRAM CHIEF. INDIVIDUAL PROGRAMS MAY ASK FOR ADDITIONAL INFORMATION.

Please
Attach
Photo

FELLOWSHIP TO BEGIN JULY -

NAME-

ADDRESS -

CITY / STATE / ZIP -

TELEPHONE (WORK) -

(HOME) -

FAX -

E-MAIL-

SOC. SEC. NO. -

DATE/PLACE OF BIRTH-

Residence ADDRESS (IF DIFFERENT) -

UNDERGRADUATE EDUCATION

COLLEGE OR UNIVERSITY

DATES ATTENDED

DEGREE

<i>COLLEGE OR UNIVERSITY</i>	<i>DATES ATTENDED</i>		<i>DEGREE</i>
NAME-	From	To	

LOCATION-

HONORS -

COLLEGE OR UNIVERSITY

DATES ATTENDED

DEGREE

<i>COLLEGE OR UNIVERSITY</i>	<i>DATES ATTENDED</i>		<i>DEGREE</i>
NAME-	From	To	

LOCATION-

HONORS-

GRADUATE EDUCATION (NON-MEDICAL)

<i>SCHOOL</i>	<i>DATES ATTENDED</i>		<i>AREA OF STUDY/DEGREE</i>
NAME-	From	To	
LOCATION-			
HONORS -			
GRADUATION DATE-			

<i>SCHOOL</i>	<i>DATES ATTENDED</i>		<i>AREA OF STUDY/DEGREE</i>
NAME-	From	To	
LOCATION-			
HONORS -			
GRADUATION DATE-			

MEDICAL EDUCATION

<i>MEDICAL SCHOOL</i>	<i>DID YOU GRADUATE?</i>		<i>DEGREE</i>
NAME-	Yes	No	
LOCATION-			
HONORS -			

<i>MEDICAL SCHOOL</i>	<i>DID YOU GRADUATE?</i>		<i>DEGREE</i>
NAME-	Yes	No	
LOCATION-			
HONORS -			

PG YEARS

<i>HOSPITAL-LOCATION</i>	<i>DATES</i>		<i>SPECIALTY-DIRECTOR</i>
1.	FROM	TO	
2.	FROM	TO	
3.	FROM	TO	
4.	FROM	TO	
5.	FROM	TO	

NATIONAL BOARD EXAMS #	ECFMG #	FLEX EXAM #	D.O. EXAM #
<i>PART #1</i> DATE- SCORE-	DATE-	<i>PART #1</i> DATE- SCORE-	DATE-
<i>PART #2</i> DATE- SCORE-	SCORE-	<i>PART #2</i> DATE- SCORE-	SCORE-
<i>PART #3</i> DATE- SCORE-			
BOARD CERTIFICATION			
<i>NAME</i>	<i>YEAR</i>	<i>NAME</i>	<i>YEAR</i>

LICENSURE (ENCLOSE COPIES)

STATE- NUMBER-	STATE- NUMBER-	STATE- NUMBER-
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ANY SUSPENSIONS, RESTRICTIONS, DISCIPLINARY ACTIONS? (PLEASE DESCRIBE)

DO YOU HAVE ANY HEALTH PROBLEMS WHICH WOULD AFFECT YOUR FELLOWSHIP PERFORMANCE OR ABILITIES? (PLEASE DESCRIBE)

RESEARCH EXPERIENCE AND GRANT EXPERIENCE

PUBLICATIONS AND PRESENTATIONS (ATTACH COPIES OF PUBLICATION)

REFERENCES: SEND TO PROGRAM DIRECTOR

PLEASE OBTAIN THREE PROFESSIONAL REFERENCES INCLUDING A SHOULDER/ELBOW SURGEON AND THE CHIEF OF YOUR RESIDENCY PROGRAM AND ALSO FORWARD A COPY OF YOUR MEDICAL SCHOOL TRANSCRIPT. THESE REFERENCE LETTERS SHOULD SPECIFICALLY ANSWER THE FOLLOWING QUESTIONS:

1. HOW WOULD YOU RANK (%) THE APPLICANT IN HIS RESIDENCY OVER THE PAST FIVE YEARS COMPARED TO ALL OTHER RESIDENTS DURING THAT TIME PERIOD?
2. ARE YOU AWARE OF ANY PARAPROFESSIONAL OR PEER CONFLICTS THAT HAVE OCCURRED WITH THE APPLICANT?
3. IS THE APPLICANT SKILLFUL AND CAREFUL? WOULD YOU TRUST HIM WITH ONE OF YOUR PATIENTS?
4. IF YOU HAVE MORE THAN ONE APPLICANT APPLYING FOR A SHOULDER/ELBOW FELLOWSHIP, HOW DOES EACH RANK COMPARED TO OTHERS?

MILITARY OR GOVERNMENT SERVICE

BRANCH-

DATES-

CURRENT STATUS-

FUTURE OBLIGATIONS-

SPECIAL INTERESTS & ABILITIES(OPTIONAL) RECREATIONAL OR ATHLETIC:

PERSONAL STATEMENT- ADDRESS WHY YOU WISH ADDITIONAL SHOULDER/ELBOW SURGERY TRAINING AND EXPLAIN ANYINTERRUPTIONS IN YOUR EDUCATION OR TRAINING. YOUR STATEMENT MAY BE ATTACHED AS A SEPARATE SHEET; DO **NOT** EXCEED ONE PAGE.

INVITATION FOR INTERVIEW IS DEPENDENT UPON A COMPLETED APPLICATION, INCLUDING SPECIFIED COPIES AND REFERENCE LETTERS. IN SIGNING THIS APPLICATION, I CERTIFY THAT ALL OF THE FOREGOING INFORMATION IS A COMPLETE AND ACCURATE STATEMENT OF THE FACTS. I AUTHORIZE YOU TO INVESTIGATE ANY AND ALL OF MY REFERENCES AND TO CONFIRM EDUCATIONAL INFORMATION. I UNDERSTAND THAT FALSE INFORMATION IS GROUNDS FOR IMMEDIATE DISMISSAL. I AGREE TO NOTIFY YOU PROMPTLY OF ANY CHANGE IN MY STATUS. I UNDERSTAND THAT ALL APPOINTMENTS ARE FOR ONE YEAR.

SIGNATURE-

DATE-
