

UNIVERSAL ORTHOPEDIC SPORTS MEDICINE FELLOWSHIP APPLICATION

THIS FORM HAS BEEN APPROVED FOR USE BY MOST PROGRAMS IN THE ORTHOPEDIC SPORTS MEDICINE FELLOWSHIP MATCH. 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

AAMC ID NO. _____
 FELLOWSHIP TO BEGIN JULY _____
 JANUARY _____
 AUGUST _____ LENGTH _____ (years)

NAME _____

ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE (WORK) _____ (HOME) _____

FAX _____ E-Mail _____

SOC. SEC. NO. _____

Residence ADDRESS (IF DIFFERENT) _____

UNDERGRADUATE EDUCATION

COLLEGE OR UNIVERSITY		DATES ATTENDED		DEGREE
1.	NAME	FROM	TO	
	LOCATION			
	HONORS			
2.	NAME	FROM	TO	
	LOCATION			
	HONORS			

GRADUATE EDUCATION (NON-MEDICAL)

SCHOOL		DATES ATTENDED		AREA OF STUDY	DEGREE
1.	NAME	FROM	TO		
	LOCATION				GRADUATION DATE
	HONORS				
2.	NAME	FROM	TO		

LOCATION

GRADUATION DATE

HONORS

MEDICAL EDUCATION

MEDICAL SCHOOL

Did you graduate?

1. NAME	Yes	No	Degree Received
LOCATION			
HONORS			
2. NAME	Yes	No	Degree Received
LOCATION			
HONORS			

PG YEARS

HOSPITAL - LOCATION	DATES		SPECIALTY - DIRECTOR
1.	FROM	TO	
2.	FROM	TO	
3.	FROM	TO	
4.	FROM	TO	
5.	FROM	TO	

NATIONAL BOARD EXAMS	ECFMG	FLEX EXAM	D.O. EXAM
# _____	# _____	# _____	# _____
PART #1 _____ DATE SCORE	DATE	PART #1 _____ DATE SCORE	DATE _____
PART #2 _____ DATE SCORE	SCORE	PART#2 _____ DATE SCORE	SCORE _____
PART #3 _____ DATE SCORE			

BOARD CERTIFICATION

NAME _____	YEAR _____	NAME _____	YEAR _____
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LICENSURE (ENCLOSE COPIES)

STATE _____
NUMBER _____

STATE _____
NUMBER _____

STATE _____
NUMBER _____

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 FOUR PROFESSIONAL REFERENCES INCLUDING A SPORTS MEDICINE 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 SPORTS MEDICINE FELLOWSHIP, HOW DOES EACH RANK COMPARED TO THE 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 SPORTS MEDICINE SURGERY TRAINING AND EXPLAIN ANY INTERRUPTIONS 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 _____