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| UR medicine logo | University of Rochester Department of Physical Medicine and Rehabilitation |

# Musculoskeletal Medicine Fellowship Application

Please complete and submit via email to taylor\_johnson@urmc.rochester.edu, or fax to (585) 442-2949

Please include with your application:

[ ]  C.V.

[ ]  Transcripts of USMLE/COMLEX scores

[ ]  Letter of Intent

[ ]  Three Letters of Recommendation (to be submitted directly by the individuals)

## Applicant Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. MD/DO/PhD |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email: |  |

|  |  |
| --- | --- |
| Current Hospital/Institution: |  |

 *Name City/State*

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| --- | --- | --- |
| Have you ever been denied a license and/or privilege? | YES[ ]  | NO[ ]  |

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| If yes, please provide more information: |  |
| Were you ever placed on probation during your residency? | YES[ ]  | NO[ ]  |

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| If yes, please provide more information: |  |

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| Are you required to fulfill any service obligations post-fellowship (i.e.National Health Service Corps, Armed Forces Scholarship, state programs, etc.)? | YES[ ]  | NO[ ]  |  |
| If yes, explain: |  |
| Citizenship: | [ ]  U.S. | [ ]  Other (specify) |  |  Visa Status: |  |

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| USMLE Scores: |  |

 *Step 1 Date Step 2 CK Date Step 2 CS Date Step 3 Date*

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| COMLEX Scores: |  |

 *Level 1 Date Level 2-CE Date Level 2-PE Date Level 3 Date*

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| Licensure: |  |

*(If applicable) State License Type License Number Expiration (MM/YY)*

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| Licensure: |  |

*(If applicable) State License Type License Number Expiration (MM/YY)*

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| Board Certification: |  |

*(If applicable) State Specialty Year Certified Expires*

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| Board Certification: |  |

*(If applicable) State Specialty Year Certified Expires*

## Education

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| --- | --- |
| Residency: |  |

 *Program/Hospital Name, Location Specialty Dates (MM/YY-MM/YY)*

|  |  |
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| Honors/Awards: |  |

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| --- | --- |
| Residency: |  |

 *Program/Hospital Name, Location Specialty Dates (MM/YY-MM/YY)*

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| Honors/Awards: |  |

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| Internship: |  |

 *Program/Hospital Name, Location Specialty Dates (MM/YY-MM/YY)*

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| Honors/Awards: |  |

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| Medical School: |  |

 *Institution Name, Location Degree Dates (MM/YY-MM/YY)*

|  |  |
| --- | --- |
| Honors/Awards: |  |

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| --- | --- |
| Graduate School: |  |

*(if applicable)* *Institution Name, Location Degree & Major Dates (MM/YY-MM/YY)*

|  |  |
| --- | --- |
| Honors/Awards: |  |

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| --- | --- |
| Undergraduate: |  |

 *Institution Name, Location Degree & Major Dates (MM/YY-MM/YY)*

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| --- | --- |
| Honors/Awards: |  |

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| Undergraduate: |  |

 *Institution Name, Location Degree & Major Dates (MM/YY-MM/YY)*

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| --- | --- |
| Honors/Awards: |  |

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| --- | --- |
| Research Experience: |  |

*(if applicable)* *Institution Name, Location Research Topic Dates (MM/YY-MM/YY)*

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| Honors/Awards: |  |

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| --- | --- |
| Research Experience: |  |

*(if applicable)* *Institution Name, Location Research Topic Dates (MM/YY-MM/YY)*

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| Honors/Awards: |  |

## Letters of Recommendation

Letters of Recommendation have been requested from the following individuals:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Title: |  |
| Institution: |  | Phone: |  |
| Address: |  |  |  |
|  |  |  |  |
| Name: |  | Title: |  |
| Company: |  | Phone: |  |
| Address: |  |  |  |
|  |  |  |  |
| Name: |  | Title: |  |
| Company: |  | Phone: |  |
| Address: |  |  |  |
|  |  |  |  |

## [ ]  I hereby waive the right to access the above letters and will so inform the authors

## [ ]  I hereby reserve the right to access the above letters and will so inform the authors

## Signature

|  |
| --- |
| By typing your name below you are submitting an e-signature which will act as your signature confirming your understanding and adherence to the following statement:I certify that the information submitted in this application, and in supplemental documents, is complete and accurate to the best of my knowledge. I understand that any false or misleading information may disqualify me from this position. |
| Signature: |  | Date: |  |