PHOTO

(PASSPORT SIZE)

FELLOWSHIP APPLICATION

HOSPITAL FOR SPECIAL SURGERY

Affiliated With
NewYork-Presbyterian Hospital
AND
Weill Medical College of Cornell University

535 East 70 Street
New York, New York 10021

NOTE: Please type or print clearly all entries

FOR OFFICE USE ONLY

Received _____

Reviewed _____

Interviewed _____

Result _____

FELLOWSHIP BEGINNING JULY/AUGUST 1, _____ DATE OF APPLICATION: _____

TYPE OF FELLOWSHIP DESIRED: _____

NAME: _____ D.O.B.: ____/____/____
Last First Middle month day year

PRESENT ADDRESS: _____
Street City State Zip Code

PHONE: HOME: _____ WORK / PAGER: _____
(include city and country code if applicable)

PERMANENT ADDRESS: _____
Street City State Zip Code

CITIZENSHIP: _____ PLACE OF BIRTH: _____
(City / State / Country)

E-MAIL: _____

SINGLE: _____ MARRIED: _____ NAME OF SPOUSE: _____

CHILDREN (Names and Ages): _____

NEAREST RELATIVE NAME(S): _____

ADDRESS: _____
Street City State Zip Code

PHONE: DAY: _____ EVENING: _____

EDUCATION

UNDERGRADUATE COLLEGES (other than medical school)

Name	Address	Degree	Month/Year

GRADUATE SCHOOL (other than medical school)

MEDICAL SCHOOL

Name	Years Attended	Degree	Month/Year

INTERNSHIP

PGY 1 _____
Hospital Address

_____ _____
Type From To

RESIDENCY

PGY2 _____
Hospital Address

_____ _____
Type From To

PGY3 _____
Hospital Address

_____ _____
Type From To

PGY4 _____
Hospital Address

_____ _____
Type From To

PGY5 _____
Hospital Address

_____ _____
Type From To

FELLOWSHIPS (other) _____
Dates

_____
Dates

NAME _____

NEW YORK STATE LICENSE _____ Year _____ Expires _____

LICENSED IN THE STATE OF _____ Year _____

ECFMG - Number _____ Year _____

VQE - Number _____ Year _____

FMGEMS - Number _____ Year _____

OTHER: Type of Visa _____ Year _____

MILITARY STATUS

Branch: _____ Dates _____

Future Obligation: YES _____ NO _____

Explain: _____

_____

RESEARCH PROJECTS:

Project	Place	Year

PUBLICATIONS: (list and provide reprints)

PRESENTATIONS: (list)

AWARDS AND HONORS:

PREVIOUS EXPERIENCE: (other than in medicine)

To complete your application, please arrange for the following to be sent to the address below.

I. Official Medical School Dean's Letter
II. Official Medical School Transcript
III. Curriculum Vitae
IV. Personal Statement (one page)
V. Three Letters of Professional Reference (including one from Chief of Residency Program)

LIST NAMES AND INSTITUTIONS/ADDRESSES:

1. _____

_____

2. _____

_____

3. _____

_____

I certify that the foregoing information is accurate to the best of my knowledge. I agree to notify Hospital for Special Surgery of any change in my status by January 1st of the year I have applied to commence my Fellowship.

_____
SIGNATURE OF APPLICANT

_____
DATE

The application must be completed in its entirety or it cannot be processed.

APPLICATION AND ALL RELATED COMMUNICATIONS SHOULD BE ADDRESSED TO:

Fellowship Selection Committee
Academic Training Department
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
(212) 606-1466