



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)

SOCIAL SECURITY NO.: _____ / _____ / _____ E-MAIL: _____

SINGLE: _____ MARRIED: _____ NAME OF SPOUSE: _____

CHILDREN (Names and Ages): _____

NEAREST RELATIVE NAME(S): _____

ADDRESS: _____
Street City State Zip Code

PHONE: DAY: _____ EVENING: _____

NAME _____

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**