

NOTE: Please type or print clearly all entries



FOR OFFICIAL USE ONLY	
Received:	Interviewed:
Reviewed:	Result:

Musculoskeletal Radiology Fellowship Application

1. Type of Fellowship	2. Fellowship Beginning JULY 1, 20 _____
<input type="checkbox"/> General Musculoskeletal Imaging	3. Application Date
<input type="checkbox"/> Musculoskeletal MRI	
<input type="checkbox"/> Either	

APPLICANT INFORMATION

4. DOB M/D/Y ____ / ____ / ____	5. Last Name	6. MI	7. First Name	PHOTO	
8. Present Address	9. City	10. State	11. Zip		
12. Social Security No.	13. Citizenship	14. Place of Birth (City/State/Zip)			
15. Permanent Address	16. City	17. State	18. Zip		
19. Best Way to Contact You:	<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Pager		<input type="checkbox"/> Email
20. Home Phone	21. Work Phone	22. Pager	23. Email		

EDUCATION

UNDERGRADUATE COLLEGES (other than medical school)			
Name	Address	Degree	Month/Year
GRADUATE SCHOOL (other than medical school)			
Name	Address	Degree	Month/Year

Name:

MEDICAL SCHOOL			
Name	Years Attended	Degree	Month/Year
INTERNSHIP			
PGY1	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			
			Dates
			Dates

Name:

CREDENTIALS			
NYS License	Year	Expires	MILITARY STATUS Branch _____ Date _____ Future Obligations: <input type="checkbox"/> YES <input type="checkbox"/> NO Explain _____
Licensed in the state of:	Year		
ECFMG No.	Year		
VQE No.	Year		
FMGEMS No.	Year		
RESEARCH PROJECTS			
Projects	Place	Year	
PUBLICATIONS (list and provide reprints)			
PRESENTATIONS (list)			
AWARDS AND HONORS			
PREVIOUS EXPERIENCE (other than in medicine)			



Musculoskeletal Radiology Fellowship Application

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

1. Official Medical School Dean's Letter
2. Official Medical School Transcript
3. Curriculum Vitae
4. Personal Statement (one page)
5. Three Letters of Professional Reference, ideally including one from a Musculoskeletal Radiologist with whom you have worked

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 _____

Requirements

- Candidates for the Clinical Fellowship must be Board Certified or Board Eligible in Diagnostic Radiology or have foreign equivalent.
- A valid license to practice medicine in the State of New York is a Hospital mandate.

Fellowship offers are made approximately 2 years prior to the anticipated Fellowship start date. All application materials must be submitted by August 1, approximately 22 months prior to the anticipated July fellowship start date. Applications missing materials after the August 1 deadline **will not be considered**.

Fellowship Year	Deadline
2017-2018	August 1, 2015
2018-2019	August 1, 2016
2019-2020	August 1, 2017
2020-2021	August 1, 2018

- The application must be completed in its entirety or it cannot be processed.
- Application and all related communications should be addressed to:

**Department of Radiology & Imaging
Fellowship Selection Committee
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
(212) 606-1936
FAX: 212-734-7378**