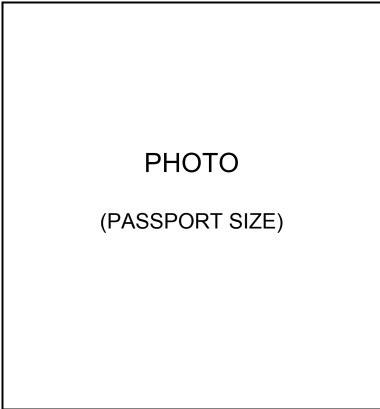

FELLOWSHIP APPLICATION

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: ____________________ (Last / First / Middle) D.O.B.: ____ / ____ / ____ (month / day / year)

PRESENT ADDRESS: ____________________ (Street / City / State / Zip Code)

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

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)

NAME ____

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