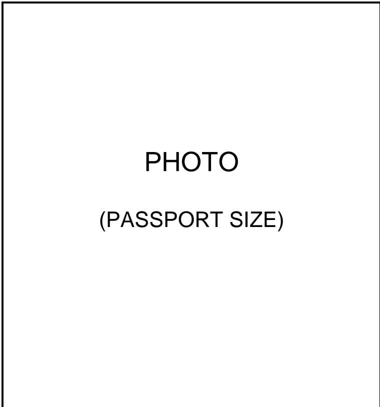

FELLOWSHIP APPLICATION

HOSPITAL FOR SPECIAL SURGERY

535 East 70 Street
New York, New York 10021

Affiliated With
NewYork-Presbyterian Hospital
AND
Weill Cornell Medical College

FOR OFFICE USE ONLY

Received ___________________

Reviewed ___________________

Interviewed ___________________

Result ___________________

NOTE: Please type or print clearly all entries

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)

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:

Jonathan S. Kirschner, MD, RMSK
ATTN: Victoria Guerrero
Hospital for Special Surgery
535 E. 70th Street
New York, NY 10021
Tel. (212) 774-2131