NOTE: Please type or print clearly all entries

HSS Radiology and Imaging
HOSPITAL FOR SPECIAL SURGERY

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

Musculoskeletal Radiology Fellowship Application

1.Type of Fellowship	2. Fellowship Beginning
☐ General Musculoskeletal Imaging	JULY 1, 20 ____
☐ Musculoskeletal MRI	3. Application Date
☐ Either	

APPLICANT INFORMATION

4. DOB M/D/YY	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:	☐ Home	☐ Work	☐ Pager	☐ 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**	
Licensed in the state of:	Year		Branch	Date
ECFMG No.	Year		Future Obligations: ☐ YES ☐ NO	
VQE No.	Year		Explain	
FMGEMS No.	Year			

RESEARCH PROJECTS

Projects	Place	Year

PUBLICATIONS (list and provide reprints)

PRESENTATIONS (list)

AWARDS AND HONORS

PREVIOUS EXPERIENCE (other than in medicine)

HSS Radiology and Imaging
HOSPITAL FOR SPECIAL SURGERY

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
2018-2019	August 1, 2016
2019-2020	June 1, 2017
2020-2021	August 1, 2018
2021-2022	August 1, 2019

- 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