

**Hospital for Special Surgery – China Orthopaedic
Education Exchange
Research Program**

Please complete the following application in English.

I. APPLICANT INFORMATION

Last Name: _____ MI: _____ First Name: _____

Male _____ Female _____ Birth Date: _____ Place of Birth: _____

Citizenship: _____

Present Home Address:

Home Telephone: _____ Cell Phone: _____ Email: _____

Permanent Address (if different):

II. NAME OF INSTITUTION, DATES AND DEGREES FOR THE FOLLOWING:

Graduate of College/University: _____ Date of Graduation: _____

Graduate of Medical School: _____ Date of Graduation: _____

III. POST-GRADUATE EDUCATION (*List Residency Rotations*)

	Institution Name/Location	From (mo/year) to (mo/year)
1 st Year:	_____	_____
2 nd Year:	_____	_____
3 rd Year:	_____	_____
4 th Year:	_____	_____
5 th Year:	_____	_____

IV. ADDITIONAL EDUCATION OR FELLOWSHIP

Institution Name/Location:

From (mo/year) to (mo/year):

Type of Fellowship:

Name of Director:

Activity during Fellowship:

V. LICENSE TO PRACTICE MEDICINE *(Submit copy if applicable)*

Country of License: _____ License number: _____ Expiration Date: _____

Restrictions, if any: _____

VI. IF EMPLOYED, PRESENT POSITION *(Title, Institution, Department)*

Mailing Address:

Work Phone: _____ Work Email: _____

Present Supervisor *(Name and Title)*: _____

Requested dates of Research Fellowship at HSS (1-2 years): _____

**Minimum 1 year commitment*

We will try our best to accommodate your preferences.

VII. DESCRIBE THE AREAS OF YOUR SPECIAL INTEREST IN ORTHOPAEDICS AND FUTURE CAREER PLANS (*Submit separate page*)

VIII. PERSONAL STATEMENT DESCRIBING WHAT SETS YOU APART AS A CANDIDATE FOR THIS EXCHANGE PROGRAM (*Submit separate page*)

PLEASE NOTE THAT THERE IS A \$500 FEE UPON ACCEPTANCE INTO THE PROGRAM

IN SIGNING THIS APPLICATION, I CERTIFY THAT ALL OF THE FOREGOING INFORMATION IS A COMPLETE AND ACCURATE STATEMENT OF THE FACTS. I AUTHORIZE YOU TO INVESTIGATE AND VERIFY ALL THE INFORMATION THAT I HAVE PROVIDED IN THIS APPLICATION. I UNDERSTAND THAT FALSE INFORMATION IS GROUNDS FOR IMMEDIATE DISMISSAL. I AGREE TO NOTIFY YOU PROMPTLY OF ANY CHANGES IN MY STATUS.

I UNDERSTAND THAT IF I AM OFFERED A SPACE IN THIS PROGRAM AND ACCEPT SUCH OFFER, I WILL BE ENROLLED IN A NON-ACCREDITED ORTHOPAEDIC OBSERVERSHIP PROGRAM AND I WILL NOT BE PERMITTED TO RECEIVE SALARY SUPPLEMENTATION FROM ANOTHER FELLOWSHIP OR SIMILAR AWARD.

Signature of Applicant: _____ **Date:** _____

PLEASE SUBMIT THE FOLLOWING VIA EMAIL:

- 1) A recent **DIGITAL** photo
- 2) Two recommendation letters
- 3) Copy of medical school transcript and diploma (in English)
- 4) Curriculum Vitae to include:
 - Special awards and honors while in medical school, residency, or fellowship
 - Membership/Leadership positions held on National, Regional or Local committees or in professional organizations
 - Peer-reviewed articles (published and in Press)
 - Non-peer reviewed articles
 - Textbooks and textbook chapters you have authored or co-authored
 - Other media: List movies, audio tapes, video tapes, which you have developed or co-developed
 - National/Regional/Local scientific presentations
 - Peer-reviewed research grants
 - Non-peer reviewed research grants
 - Non-academic achievements and community service activities

Please email completed documents to rubeoa@hss.edu

For questions or concerns please contact Allie Rubeo at rubeoa@hss.edu