FELLOWSHIP APPLICATION

HOSPITAL FOR SPECIAL SURGERY

Affiliated With
New York-Presbyterian Hospital
AND
Weill Cornell Medical College

535 East 70 Street
New York, New York 10021

NOTE: Please type or print clearly all entries

FELLOWSHIP DESIRED: Research Fellowship: Choose one

FELLOWSHIP BEGINNING JULY/AUGUST 1, _____ DATE OF APPLICATION: _____

I. DEMOGRAPHIC INFORMATION:

NAME: _____ D.O.B.: ____/____/____
Last First Middle month day year

PRESENT ADDRESS: _____
Street City State Zip Code

PHONE: _____
(include city and country code if applicable)

PERMANENT ADDRESS: _____
Street City State Zip Code

CITIZENSHIP: _____ PLACE OF BIRTH: _____
(Country)

E-MAIL: _____

SINGLE: _____ MARRIED: _____ FAMILY SIZE: _____

II. EDUCATION:

MEDICAL SCHOOL

Name	Years Attended	Degree	Month/Year

III. DEMOGRAPHIC INFORMATION:

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

IV. MILITARY STATUS

Branch: _____ Dates _____

Future Obligation: YES _____ NO _____

Explain: _____

V. WORK ELIGIBILITY:

1. Have you completed medical school outside the United States? **Yes/No**
2. If yes, please provide your ECFMG Number: _____ Issue Date: _____ Expiration Date: _____
3. Have you completed an ACGME, RCPSC, ACGME-I accredited residency program? **Yes/No**
4. Do you currently possess required citizenship, lawful permanent resident status, or an appropriate visa that will allow you to remain in the U.S. or Canada to complete the entire duration of the fellowship program(s) to which you are applying? **Yes/No**
5. Do you currently require, or might you potentially require in the future, sponsorship from an employer or other organization in order to obtain, extend, or renew a visa that will allow you to complete the fellowship program(s) to which you are applying? **Yes/No**
6. Type of Visa (if applicable): _____

VI. REQUIRED INFORMATION:

1. Medical License in the State of: _____Year: _____Expires: _____
2. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked? Yes/No
3. Is your license the subject of a pending action or investigation? Yes/No
4. Have your privileges at any hospital ever been denied, suspended, restricted, revoked, deferred, or reviewed pursuant to disciplinary action or not renewed? Yes/No
5. Have you ever withdrawn your application for privileges at a hospital? Yes/No
6. Have you ever been counseled, censured, or subject to disciplinary action in any medical organization, educational institution, or practice facility? Yes/No
7. Are you currently involved in any litigation involving patient care? Yes/No
8. Have you ever been involved in a medical lawsuit in which there was an adverse settlement, judgment or sanction? Yes/No
9. Have you ever been reported to the National Practitioner Data Bank? Yes/No
10. **If the answer to any of the Required Data questions (2-9) is YES, please GIVE FULL DETAILS below:**

_____

11. With the exception of the program (if any) that you are currently still in, were there any internships, residencies, or fellowships that you did not complete in good standing? Yes/No
12. Have you ever been placed on probation by your school or residency program? Yes/No
13. **If the answer to either of these questions (11-12) is yes, please explain below:**

_____

VII. ADDITIONAL DOCUMENTS:

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

I. Curriculum Vitae

II. USMLE Scores

III. ECFMG Certificate (if applicable)

IV. Personal Statement (one page)

V. Three Letters of Professional Reference (*including one from Program Director of your Residency Program*)

LIST NAMES AND INSTITUTIONS:

1. _____

2. _____

3. _____

I certify that the foregoing information is accurate to the best of my knowledge.

_____

SIGNATURE OF APPLICANT

_____

DATE

APPLICATION AND ALL RELATED COMMUNICATIONS SHOULD BE ADDRESSED TO YOUR PROGRAM ADMINISTRATOR. PLEASE CONTACT MARLISA VERIDIANO: veridianom@hss.edu