

2013 AHNS FELLOWSHIP APPLICATION

IDENTIFYING INFORMATION (ALL INFORMATION MUST BE COMPLETE)		
Last Name:	First:	Middle:
Home Mailing Address:	City:	
	State:	Zip:
Home Telephone Number (required):	Cell Phone Number (required):	
Work Mailing Address:	City:	
	State:	Zip:
Work Email Address (required):	Personal Email Address (required):	
Birth Date:		
Birth Place (City/State/Country):		
Citizenship:	Visa (if not US citizen):	
Social Security Number:	ECFMG Number:	
Outside Interests & Hobbies:		
PRE-MEDICAL EDUCATION		
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
POSTGRADUATE EDUCATION – PLEASE ENCLOSE A COPY OF YOUR CV		
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:

RESIDENCIES/FELLOWSHIPS			
Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city, zip code, and dates. Include <u>All</u> programs you attended, whether or not completed.			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (e.g., residency, etc):	Specialty:	From:	To:
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "no", please explain)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (e.g., residency, etc):	Specialty:	From:	To:
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "no", please explain)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (e.g., residency, etc):	Specialty:	From:	To:
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "no", please explain)			
PEER REFERENCES			
List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Please obtain original letters of reference from these three individuals and submit them along with your application. NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.			
Name of Reference:		Specialty:	Telephone Number:
Mailing Address:		City:	
		State:	Zip:
Name of Reference:		Specialty:	Telephone Number:
Mailing Address:		City:	
		State:	Zip:
Name of Reference:		Specialty:	Telephone Number:
Mailing Address:		City:	
		State:	Zip:

OTHER

Board Certification: Yes No

License Number: _____ State: _____ Exp: _____

Honors and Awards:

In-training exam score (all years): _____1st _____2nd _____3rd _____4th

PROFESSIONAL LIABILITY

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? Yes No

If “yes”, please provide list and status on a separate sheet.

Comments: _____

DISCIPLINARY ACTIONS

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, placed on probation, not renewed, or voluntarily relinquished? If “yes”, please provide full explanation on a separate sheet.

- Medical license in any state Yes No
- Other professional registration/license Yes No
- DEA registration Yes No
- Academic appointment Yes No
- Membership on any hospital medical staff Yes No
- Clinical privileges Yes No
- Prerogative/rights on any medical staff Yes No
- Other institutional affiliation or status threat Yes No
- Professional society membership or fellowship/Board certification Yes No
- Professional office Yes No
- Any other type of professional sanction Yes No
- Professional liability insurance Yes No
- Have there been any felony criminal charges brought against you in the last 5 years. . . Yes No
- Have you been convicted of any crimes Yes No

PERSONAL STATEMENT (Please make this statement about 800 words and Do Not exceed 1 page)

SIGNATURE:

I hereby certify that, to the best of my knowledge and belief, I have no physical or mental illness or mental defect that interferes with my professional appointment. All information submitted by me in this application is true and accurate to the best of my knowledge and belief. I agree to be a participant in the American Head and Neck Society 2012 match. I agree to submit my match list prior to the deadline of June 15, 2012. **If I wish to withdraw from the match, I must do so prior to June 1, 2012 by contacting the AHNS office and all of the program(s) that I have applied to.**

Signature: _____ Date: _____

Checklist for 2013 Match Applicants

Programs Participating in the 2013 Fellowship Match:

- | | | |
|--|---------------------------------------|----------------|
| _____ Beth Israel Medical Center (1 position) | Application fee: | \$50.00 |
| _____ Emory University (1 position) | | |
| _____ Indiana University School of Medicine (1 position) | _____ # of programs x \$15.00: | _____ |
| _____ Johns Hopkins University (1 position) | | |
| _____ M.D. Anderson Cancer Center (3 positions) | Total amount enclosed: | _____ |
| _____ Medical College of Georgia (1 position) | | |
| _____ Medical University of South Carolina (1 position) | | |
| _____ Memorial Sloan-Kettering Cancer Center (3 positions) | | |
| _____ Mount Sinai School Of Medicine (1 position) | | |
| _____ Ohio State University (1 position) | | |
| _____ Roswell Park Cancer Institute (2 positions) | | |
| _____ Stanford University (1 position) | | |
| _____ University of Alabama: Birmingham (1 position) | | |
| _____ University of Alberta (1 position) | | |
| _____ University of California, Davis (2 positions) | | |
| _____ University of Cincinnati (1 position) | | |
| _____ University of Iowa (1 position) | | |
| _____ University of Kansas School of Medicine (1 position) | | |
| _____ University of Manitoba (1 position) | | |
| _____ University of Miami (2 positions) | | |
| _____ University of Michigan (1 position) | | |
| _____ University of Nebraska (1 position) | | |
| _____ University of Oklahoma (1 position) | | |
| _____ University of Pennsylvania (2 positions) | | |
| _____ University of Pittsburgh (3 positions) | | |
| _____ University of South Florida (1 position) | | |
| _____ University of Toronto (4 positions) | | |
| _____ University of Washington (1 position) | | |
| _____ Wayne State University (1 position) | | |

Please return this application along with your payment to:

**Aaron Goodman
American Head and Neck Society
11300 W. Olympic Blvd. Suite #600
Los Angeles, CA 90064**