2017 AHNS FELLOWSHIP APPLICATION

IDENTIFYING INFORMATION (ALL INFORMATION MUST BE COMPLETE)		
Last Name:	First:	Middle:
Preferred Mailing Address:	City:	
	State:	Zip:
Preferred Phone Number:	Preferred Email Address:	
Alternate Mailing Address:	City:	
	State:	Zip:
Alternate Phone Number:	Alternate Email Address:	
Birth Date:	Birth Place (City/State/Country):	
Citizenship (if not US):	Visa (if not US Citizen):	
SSN:	ECFMG Number:	
Outside Interests/Hobbies:		
PRE-MEDICAL EDUCATION		
College/University:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
College/University:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
POST GRADUATE EDUCATION – PLEASE ATTACH YOUR CV		
College/University:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:
College/University:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State:	Zip:

RESIDENCIES / FELLOWSHIPS

Please include, in chronological order, all residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic) and postgraduate education. Please include ALL programs you attended, regardless if you completed the program or not.

Institution:	Program Director:		
Mailing Address:	City:		
	State:	Zip:	
Type of Training (e.g. residency, etc.):	Specialty:	From:	To:
Did you successfully complete the program? ____Yes _____ 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? ____Yes _____ 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? ____Yes _____ No (If No, please explain)			

PEER REFERENCES – each reference listed below should submit a letter of recommendation

Name of Reference:	Specialty:	Telephone Number:
Preferred Mailing Address:	City:	
	State:	Zip:
Name of Reference:	Specialty:	Telephone Number:
Preferred Mailing Address:	City:	
	State:	Zip:
Name of Reference:	Specialty:	Telephone Number:
Preferred 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 a 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 – Type statement here or attach a separate sheet of paper
(Please limit your statement to approximately 800 words – not to exceed 1 page)

Checklist for Programs Participating in the 2017 AHNS Fellowship Match:

Head & Neck Fellowships

_____	Beth Israel Medical Center	(1 position)
_____	Cleveland Clinic Foundation	(1 position)
_____	Emory University School of Medicine	(1 position)
_____	Indiana University School of Medicine	(1 position)
_____	Johns Hopkins University	(1 position)
_____	Massachusetts Eye & Ear Infirmary/Harvard	(1 position)
_____	MD Anderson Cancer Center	(3 positions)
_____	Mayo Clinic - Rochester	(1 position)
_____	Medical University of South Carolina	(2 positions)
_____	Memorial Sloan-Kettering Cancer Center	(2 positions)
_____	Moffitt Cancer Center	(1 position)
_____	Mount Sinai School of Medicine	(1 position)
_____	Ohio State University	(1 position)
_____	Oregon Health & Sciences University	(1 position)
_____	Roswell Park Cancer Institute	(2 positions)
_____	Thomas Jefferson University	(1 position)
_____	University of Alabama, Birmingham	(1 position)
_____	University of Alberta	(1 position)
_____	University of California, Davis	(1 position)
_____	University of California, San Francisco	(1 position)
_____	University of Cincinnati Medical Center	(1 position)
_____	University of Iowa	(1 position)
_____	University of Kansas	(1 position)
_____	University of Manitoba	(1 position)
_____	University of Miami	(2 positions)
_____	University of Michigan	(2 positions)
_____	University of Nebraska	(1 position)
_____	University of Oklahoma	(1 position)
_____	University of Pennsylvania	(2 positions)
_____	University of Pittsburgh	(3 positions)
_____	University of Toronto	(3 positions)
_____	University of Washington	(1 position)
_____	Vanderbilt University	(2 positions)
_____	Washington University at St. Louis	(2 positions)
_____	Wayne State University	(1 position)

Endocrine Fellowships

_____	Georgia Regents University/Med College of GA	(1 position)
_____	Johns Hopkins University	(1 position)
_____	MA Eye & Ear Infirmary/Harvard	(1 position)
_____	Pennsylvania State U/Hershey Medical Center	(1 position)

PAYMENT:

Application fee:	$50.00
____# of Programs x $15.00 each	_____
Total Amount Enclosed:	_____

Application checklist: (materials can be submitted separately. Applications will not be submitted to the requested programs until complete.)

___Completed 2017 Application
___Completed Personal Statement
___Professional resume or CV
___1 Recent Photo
___3 Letters of reference
___Completed Fellowship checklist
___Payment (check or credit card – for credit card, please complete the form below or call the administrative office to give the card information over the phone – 310-437-0559 x154)

Payment Type: VISA MC AMEX
Name on Card _____
Card Number: _____
Expiration Date: _____
Amount Charged: _____

IMPORTANT: All fellowship applicants are now required by the AHNS to be an AHNS Candidate member or to have an application submitted with the membership department submitted by the time the match occurs. Applications are available online at: http://www.ahns.info/member-central/. You can also contact the AHNS membership department directly at: membership@ahns.info

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 2017 match. I agree to submit my match list prior to the deadline of June 15, 2016. **If I wish to withdraw from the match, I must do so prior to June 1, 2016 by contacting the AHNS office and all of the program(s) that I have applied to.**

Signature: _____Date:_____

SUBMISSION OF APPLICATION:
Your completed application may be mailed or emailed to the AHNS administrative office. Letters of recommendation can arrive separately, and can also be emailed directly to the AHNS office from the recommender. Payment can be in the form of check or credit card. If you wish to pay by credit card, please email the AHNS administrative office – you have the option of completing a credit card authorization form or calling the office directly.

Return this application along with payment (paid to AHNS) to the AHNS Administrative Office:
JJ Jackman, Associate Executive Director
American Head and Neck Society
11300 W. Olympic Blvd. Suite #600
Los Angeles, CA 90064
or
jj@ahns.info
Questions – email or call 310-437-0559 x 154