2015 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 All 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? ___ 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

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)

Checklist for 2015 Match Applicants

Programs Participating in the 2015 AHNS Fellowship Match:

_____ Beth Israel Medical Center (1 position)
_____ Cleveland Clinic Foundation (1 position)
_____ Emory University (1 position)
_____ Georgia Regents University/Med College of GA (1 position) *(Endocrine Surgery only Fellowship)*
_____ Indiana University School of Medicine (1 position)
_____ Johns Hopkins University (2 positions)
_____ M.D. Anderson Cancer Center (3 positions)
_____ Massachusetts Eye & Ear Infirmary/Harvard Medical School (1 position)
_____ Medical University of South Carolina (2 positions)
_____ Memorial Sloan-Kettering Cancer Center (2 positions)
_____ Mount Sinai School of Medicine (1 position)
_____ Ohio State University (1 position)
_____ Oregon Health & Sciences University (1 position)
_____ Roswell Park Cancer Institute (2 positions)
_____ Southern Illinois University School of Medicine (1 position)
_____ Stanford University (1 position)
_____ Thomas Jefferson University (1 position)
_____ University of Alabama: Birmingham (1 position)
_____ University of Alberta (1 position)
_____ University of California, Davis (2 positions)
_____ University of California, San Francisco (1 position)
_____ University of Cincinnati (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 South Florida (1 position)
_____ University of Toronto (4 positions)
_____ University of Washington (1 position)
_____ Wayne State University (1 position)

PAYMENT:

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

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

All fellowship applicants are also requested to submit a photo with their application.

SIGNATURE:

I hearby 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 2015 match. I agree to submit my match list prior to the deadline of June 15, 2014. **If I wish to withdraw from the match, I must do so prior to June 1, 2014 by contacting the AHNS office and all of the program(s) that I have applied to.**

Signature:_____Date:_____

Please return this application, along with your payment (paid to AHNS) to:

JJ Jackman
American Head and Neck Society
11300 W. Olympic Blvd. Suite #600
Los Angeles, CA 90064