2018 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:	
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 also 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 2018 AHNS Fellowship Match:

Head & Neck Fellowships

_____Beth Israel Medical Center	(1 position)
_____Cleveland Clinic Foundation	(1 position)
_____Duke University	(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)
_____Nebraska Methodist Hospital	(1 position)
_____Ohio State University	(1 position)
_____Oregon Health & Sciences University	(1 position)
_____Roswell Park Cancer Institute	(2 positions)
_____Stanford University	(1 position)
_____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 North Carolina – Chapel Hill	(1 position)
_____University of Oklahoma	(1 position)
_____University of Pennsylvania	(2 positions)
_____University of Pittsburgh	(3 positions)
_____University of Toronto	(4 positions)
_____University of Washington	(1 position)
_____Vanderbilt University Medical Center	(2 positions)
_____Washington University at St. Louis	(2 positions)

Endocrine Fellowships

_____Augusta University	(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 2018 Application
___ Completed Personal Statement
___ Professional resume or CV
___ 1 Recent Photo
___ 3 Letters of reference
___ Completed Fellowship checklist
___ AHNS Membership Application submitted**
___ Payment (check or credit card – for credit card, please complete the form below or call the administrative office (310-437-0559 x154)

Payment Type: VISA MC AMEX

Name on Card _____

Card Number: _____

Expiration Date: _____

Amount Charged: _____

**IMPORTANT: All fellowship applicants are required to be an AHNS Candidate member or to have an application submitted or in process with the membership department before the Fellowship match occurs. Applications online at http://www.ahns.info/member-central/, or 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 2018 match. I agree to submit my match list prior to the deadline of June 15, 2017. **If I wish to withdraw from the match, I must do so prior to June 1, 2017 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 (email is preferred) 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