

APPLICATION FOR SPORTS MEDICINE FELLOWSHIP

American Medical Society for Sports Medicine  
 11639 EARNSHAW  
 Overland Park, KS 66210  
 (913) 327-1415 (Phone and Fax)

To Begin:                      2005                      2006                      2007                      2008

PERSONAL DATA:

\_\_\_\_\_  
 Last Name    First    Middle

\_\_\_\_\_  
 Present Address

\_\_\_\_\_  
 City                      State                      Zip/Postal Code                      Country

\_\_\_\_\_  
 Area Code/Telephone Home                      Work                      Fax

\_\_\_\_\_  
 Permanent Address

\_\_\_\_\_  
 City                      State                      Zip/Postal Code                      Country

\_\_\_\_\_  
 Area Code/Telephone Home                      Work                      Fax

Citizen of U.S.    Yes    No                                      Social Security Number \_\_\_\_\_

Are you aware of any limitation which would prevent you from performing the duties of the fellowship for which you are applying? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

EDUCATION:

\_\_\_\_\_  
 College or University                      City/State                      Dates                      Degree

\_\_\_\_\_  
 College or University                      City/State                      Dates                      Degree

\_\_\_\_\_  
 College or University                      City/State                      Dates                      Degree

\_\_\_\_\_  
 Advanced Degree School                      City/State                      Dates                      Degree

\_\_\_\_\_  
 Advanced Degree School                      City/State                      Dates                      Degree

\_\_\_\_\_  
 Medical School                      City/State                      Dates                      Degree(M.D./D.O.)

National Board of Medical Examiners Scores:    I                      II                      III  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Flex Scores:    I                      II                      III  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

US Medical License Examiners:                      I                      II                      III  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

HOSPITAL EXPERIENCE: (Please list all previous training. Use additional sheet if necessary)

PGY I	Hospital	City/State	Dates (inclusive)	Type
Residency	Hospital	City/State	Dates (inclusive)	Specialty
Residency	Hospital	City/State	Dates (inclusive)	Specialty
Residency	Hospital	City/State	Dates (inclusive)	Specialty

PREVIOUS PRACTICE EXPERIENCE:

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SPORTS MEDICINE EXPERIENCE:

Sports Medicine Rotations (date, type, location, instructor) \_\_\_\_\_

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Sports Medicine Coverage (i.e., games, events, training room)

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Sports Medicine Conferences (attended/presented) \_\_\_\_\_

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ADDITIONAL PERSONAL DATA:

1. Work Experience Prior to Medical Training

Occupation/Title

Dates

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Military Status (U.S.A.): present status and service record

a. Do you hold a Reserve commission

Yes

No

Branch \_\_\_\_\_ Rank \_\_\_\_\_

b. Have you served in the military or U.S.P.H.S.?

Yes

No

Have you attended summer training camp?

Yes

No

c. Are you required to attend reserve meetings?

Yes

No

Are you required to attend summer training camp?

Yes

No

d. Do you have a military or U.S.P.H.S. commitment?

Yes

No

To begin on \_\_\_\_\_ for \_\_\_\_\_

3. Are you certified by the E.C.F.M.G.?

Yes

No

Which Qualifying Exam Taken? \_\_\_\_\_

a. Date passed \_\_\_\_\_

b. Scores: Part I \_\_\_\_\_ Part II \_\_\_\_\_

c. Certificate number \_\_\_\_\_

d. Certificate valid through what date \_\_\_\_\_

4. If not a U.S. citizen, will you enter or remain in the U.S. on:

a. Exchange Visitor Visa \_\_\_\_\_

b. Permanent Visa Number \_\_\_\_\_

c. How many years may you remain in the U.S.A.? \_\_\_\_\_

5. Publications (author, title, publication, date - use additional sheets if necessary)

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6. Conferences Attended or Presented (other than sports medicine)

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7. Honors and Awards

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8. References and Supporting Documents:

Please ask three physicians who have supervised you in a clinical setting to send letters in support of your application.

Copies of the following documents are requested: medical school diploma, certificate for other validation of all previous training, copy of present state medical licenses, and curriculum vitae.

Please note that individual fellowships may require additional information such as (but not limited to ) letter of commendation from medical school dean, undergraduate and medical school transcripts, and rotations taken during residency.

9. Personal Statement:

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DO NOT SEND ORIGINAL DOCUMENTS. NO DOCUMENTS WILL BE RETURNED.

PHOTOCOPIES OF THIS APPLICATION WILL BE ACCEPTED. HOWEVER THE SIGNATURE ON EACH APPLICATION MUST BE ORIGINAL

I certify that the information given or attached is true, accurate and complete.

Signature \_\_\_\_\_

(Must be original)

Date \_\_\_\_\_

PLEASE SEND ALL APPLICATIONS AND SUPPORTING DOCUMENTS TO THE PRIMARY CARE SPORTS MEDICINE FELLOWSHIPS TO WHICH YOU ARE APPLYING.

DO NOT return application to the American Medical Society for Sports Medicine.

/mcb