

APPLICATION FOR PRIMARY CARE SPORTS MEDICINE FELLOWSHIP

NRMP
 2450 N Street, NW, Suite 201
 Washington, DC 20037-1141
 (202)828-0676

TO BEGIN:

2007 2008 2009 2010

Please Send: color photo (head shot) of applicant

PERSONAL DATA:

Last Name	First Name	Middle Initial
Present Address		
City ()	State ()	Zip Code ()
Country		
Home Phone	Work Phone	Cell Phone
Citizen of U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security Number _____
Email Address		

EDUCATION:

College or University	City/State	Dates	Degree
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 (MD/DO)

HOSPITAL EXPERIENCE:

PGY-I	HOSPITAL	CITY: _____	DATES (INCLUSIVE)	TYPE
_____	_____	STATE: _____	_____	_____
RESIDENCY	HOSPITAL	CITY: _____	DATES (INCLUSIVE)	TYPE
		STATE: _____		

RESIDENCY

HOSPITAL

CITY: _____

DATES
(INCLUSIVE)

TYPE

STATE: _____

NATIONAL BOARD OF MEDICAL EXAMINERS SCORES (copy or original required):

I

II

III

FLEX SCORES (copy or original required):

I

II

III

US MEDICAL LICENSE EXAMINERS (copy or original required):

I

II

III

PREVIOUS PRACTICE EXPERIENCE:

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SPORTS MEDICINE ROTATION (Dates, Type, Location, Instructor):

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SPORTS MEDICINE COVERAGE (Games, Events, Training Room, Other):

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SPORTS MEDICINE CONFERENCES:

Attended:

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Presented:

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ADDITIONAL PERSONAL DATA:

1. Work Experience Prior to Medical Training (Occupation/Title, Dates):

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2. Military Status (U.S.A.) (Present Status and Service):

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a. Do you hold a reserve Commission? Yes No

To begin:	<input type="text"/>	for	<input type="text"/>	on	<input type="text"/>
Branch:	<input type="text"/>				
Rank:	<input type="text"/>				

- 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: for on

3. Are you certified by the E.C.F.M.G.? Yes No

Which qualifying exam taken?

a. Dates 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): PLEASE INCLUDE A COPY OF THE FRONT PAGE OF ANY LISTED PUBLICATION OR A COPY OF THE PROGRAM OF ANY LISTED PRESENTATION WITH YOUR PRESENTATION.

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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 or 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 letter of commendation from medical school dean, undergraduate and medical school transcripts, and rotations taken during residency. *Contact the individual fellowships you are applying to for further application requirements and deadlines.*

9. Personal Statement:

10. Have you ever been placed on probation, suspended from your job duties, residency, training program, had privileges revoked, or been part of a malpractice complaint? If YES, please explain below

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

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:

ALL COMPLETED APPLICATIONS SHOULD BE SUBMITTED TO PROGRAMS BY OCTOBER 1.

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

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