The Bone and Joint Center (BJC) **at UPMC Magee-Womens Hospital** NAME:		
Fellowship Application		
CONTACT INFORMATION		
Full Name:		
Current Address:		
City:	State:	ZIP Code:
Country (if outside US):		
Home Phone:	Work Phone:	Cell:
Email:		Fax:
Are you legally authorized to work in the United States? ☐ No ☐ Yes Will you now or in the future require sponsorship for employment Visa status? ☐ No ☐ Yes		
PERMANENT ADDRESS (IF DIFFERENT FROM ABOVE)		
Address:		
City:	State:	ZIP Code:
Country (if outside the US):		
MILITARY SERVICE		
Do you have any military obligations? ☐ No ☐ Yes If "yes" please answer questions below.		
Branch:		Current status:
Future Obligations (time commitment):		Dates (if known):
IF A GRADUATE FROM A FOREIGN MEDICAL SCHOOL, HOW DO YOU QUALIFY (ECFMG CERTIFICATE, ETC)		
ECFMG#:		ECFMG Issue Date:
Type of VISA:		VISA#:
UNDERGRADUATE EDUCATION		
1. College/University Name:	City/State:	Degree:
Dates attended from (mm/yy) to (mm/yy):	Honors:	
2. College/University Name:	City/State:	Degree:
Dates attended from (mm/yy) to (mm/yy):	Honors:	
GRADUATE EDUCATION (NON-MEDICAL)		
1. College/University Name:		City/State:
Dates attended from (mm/yy) to (mm/yy):	Graduation Date:	Degree/Study Area:
Honors:		

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GRADUATE EDUCATION (NON-MEDICAL) CONTINUED

2. College/University Name:		City/State:
Dates attended from (mm/yy) to (mm/yy):	Graduation Date:	Degree/Study Area:
Honors:		

MEDICAL SCHOOL I

Institution Name:		City/State:
Dates attended from (mm/yy) to (mm/yy):	Graduation Date:	Degree/Study Area:
Honors:		

MEDICAL SCHOOL II

Institution Name:		City/State:
Dates attended from (mm/yy) to (mm/yy):	Graduation Date:	Degree/Study Area:
Honors:		

PG YEARS-INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS

1. Hospital/Institution:		Location (City/State/Country (if not USA)):
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
2. Hospital/Institution:		Location (City/State/Country (if not USA)):
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
3. Hospital/Institution:		Location (City/State/Country (if not USA)):
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
4. Hospital/Institution:		Location (City/State/Country (if not USA)):
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
5. Hospital/Institution:		Location (City/State/Country (if not USA)):
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:

REQUIRED DATA

1. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked? ☐ No ☐ Yes
2. Is your license the subject of a pending action or investigation? ☐ No ☐ Yes

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REQUIRED DATA CONTINUED

3. Have your privileges at any hospital ever been denied, suspended, restricted, revoked, deferred, or reviewed pursuant to disciplinary action or not renewed? ☐ No ☐ Yes
4. Have you ever withdrawn your application for privileges at a hospital? ☐ No ☐ Yes
5. Has your narcotic registration ever been suspended or revoked? ☐ No ☐ Yes
6. Have you ever been counseled, censured, or subject to disciplinary action in any medical organization, educational institution, or practice facility? ☐ No ☐ Yes
7. Are you currently involved in any litigation involving patient care? ☐ No ☐ Yes
8. Have you ever been involved in a medical lawsuit in which there was an adverse settlement, judgment or sanction? ☐ No ☐ Yes
9. Have you ever been reported to the National Practitioner Data Bank? ☐ No ☐ Yes

If the answer to any of the Required Data questions (1-9) is YES, please GIVE FULL DETAILS below.

- With the exception of the program (if any) that you are currently still in, were there any internships, residencies, or fellowships that you did not complete in good standing? ☐ No ☐ Yes
- Have you ever been placed on probation by your school or residency program? ☐ No ☐ Yes

If the answer to either of these questions is yes, please explain below.

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PLEASE ACCOUNT FOR ANY GAPS IN YOUR MEDICAL EDUCATION AND TRAINING LASTING GREATER THAN THREE MONTHS NOT LISTED IN THE PREVIOUS PAGE

Dates	Activity name	Location (city/state/country (if not USA))
1.		
2.		
3.		
4.		
5.		

EXAM RESULTS

USMLE				COMLEX			MCCQE			FLEX EXAM		
#				#			#			#		
	Date	Score	Percentile Rank		Date	Score		Date	Score		Date	Score
S1				L1			P1			P1		
S2 CK				L2 CE			P2			P2		
S2 CS				L2 PE								
S3				L3								

BOARD CERTIFICATION

Board Name	Year Certified	Expiration Date	Board Name	Year Certified	Expiration Date
1.			2.		

LICENSURES

State	License #	Expiration Date	State	License #	Expiration Date
1.			3.		
2.			4.		

Have you had any suspensions, restrictions, or disciplinary actions? ☐ If yes, please describe:

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PLUBLICATIONS AND PRESENTATIONS

OTHER QUALIFICATIONS

Honors and Awards:

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Leadership Positions, Committees, or other Professional/Service Activities:

Research Experience:

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Meetings/Courses Attended:

Extra-curricular Activities/Interests:

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PERSONAL STATEMENT (PLEASE LIMIT TO NO MORE THAN 500 WORDS)

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NAME:_____

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AGREEMENT

I certify the information in this application is true and complete and I have not withheld information that might significantly affect my qualifications for fellowship training. I understand any misrepresentation listed on this application and its accompanying documents may be cause for immediate termination of my application process or future employment. I authorize any training program that receives this application to contact any or all of my former employers, educational institutions and/or other persons or organizations that may have information relevant to my application. I understand information obtained will be treated as confidential. I intend to complete all prerequisites prior to beginning my fellowship training**.**

Signature of applicant:	Date: