CRANIOFACIAL FELLOWSHIP APPLICATION

DEMOGRAPHICS

1. NAME (LAST) (FIRST) (MIDDLE)

2. SOCIAL SECURITY NUMBER
- -

3. ECFMG REGISTRATION (IF APPLICABLE)

4. PRESENT ADDRESS (STREET)

(CITY) (STATE) (ZIP)

PRESENT PHONE NOS.

DAY ( ) EVENING ( )

5. CITIZENSHIP
☐ U.S. ☐ OTHER

6. VISA STATUS (IF APPLICABLE)
☐ PERMANENT
☐ TEMPORARY ☐ J-1 ☐ H-1

7. MARRIED
☐ YES ☐ NO

ATTACH RECENT PHOTOGRAPH

8. PERMANENT ADDRESS: C/O (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED) (STREET)

(CITY) (STATE) (ZIP)

PERMANENT PHONE NO.
( )

MEDICAL EDUCATION

9. MEDICAL SCHOOL(S) (NAME)

(CITY) (STATE/COUNTRY)

10. MONTH/YEAR OF GRADUATION

GRADUATE EDUCATION

11. GRADUATE SCHOOL(S) DATES ATTENDED GRADUATE DEGREE

A. NAME

CITY STATE

B. NAME

CITY STATE

UNDERGRADUATE EDUCATION

12. GRADUATE SCHOOL(S) DATES ATTENDED GRADUATE DEGREE

A. NAME

(CITY) (STATE)

B. NAME

(CITY) (STATE)

I HAVE ALREADY PASSED THE EXAMINATIONS CHECK BELOW ON THE DATES INDICATED:

13.

☐ USMLE, STEP I:_____ SCORE: _____
(DATE)

☐ USMLE, STEP II:_____ SCORE: _____
(DATE)

☐ USEMLE, STEP III:_____ SCORE: _____
(DATE)

14. PLASTIC SURGERY IN-SERVICE EXAM

DATE: _____
SCORE: _____
DATE: _____
SCORE: _____

BOARD CERTIFICATIONS

15.

SPECIALITY:_____ DATE: _____ CERT. NO.: _____

SPECIALITY:_____ DATE: _____ CERT. NO.: _____

LETTERS OF RECOMMENDATION

16. A. PROGRAM DIRECTOR NAME:

INSTITUTION

ADDRESS

B. NAME AND TITLE

INSTITUTION

ADDRESS

C. NAME AND TITLE

INSTITUTION

ADDRESS

D. NAME AND TITLE

INSTITUTION

ADDRESS

17. (CHECK ONE)

☐ I HEREBY WAIVE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS

☐ I DESIRE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS.

NAME OF APPLICANT (TYPED) SIGNATURE AND DATE

PERSONAL STATEMENT

18. PLEASE PROVIDE A PERSONAL STATEMENT DETAILING YOUR INTEREST AND INTENTIONS REGARDING CRANIOFACIAL SURGERY (1 - 2 PARAGRAHS)

I CERTIFY THAT THE INFORMATION SUBMITTED ON THESE APPLICATION MATERIALS IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE: I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THIS POSITION.

19.

SIGNATURE OF APPLICANT:_____ DATE:_____

NOTE: THE SIGNATURE AND DATE ON EACH APPLICATION MUST BE ORIGINAL.

APPLICATION CHECKLIST

HAVE YOU PROVIDED THE CRANIOFACIAL FELLOWSHIP WITH ALL OF THE REQUIRED INFORMATION?

- ☐ COMPLETED CRANIOFACIAL FELLOWSHIP APPLICATION
- ☐ CURRICULUM VITAE
- ☐ COPY OF USMLE SCORES
- ☐ PERSONAL STATEMENT
- ☐ THREE LETTERS OF RECOMMENDATION, INCLUDING ONE FROM YOUR PLASTIC SURGERY PROGRAM DIRECTOR

PLEASE MAIL COMPLETED CRANIOFACIAL FELLOWSHIP APPLICATION MATERIALS TO:

NINA BEEDLE
CRANIOFACIAL FELLOWSHIP COORDINATOR
3550 TERRACE STREET
SCAIFE HALL, SUITE 690
PITTSBURGH, PA 15261
TELEPHONE: 412-383-8082
FAX NUMBER: 412-383-9053
EMAIL: BEEDLEND@UPMC.EDU

IF YOU HAVE ANY QUESTIONS REGARDING THE CRANIOFACIAL FELLOWSHIP, PLEASE FEEL FREE TO CALL OR SEND AN E-MAIL REQUEST TO: NINA BEEDLE, 412-383-8082 OR BEEDLEND@UPMC.EDU

PROGRAM DIRECTOR: JOSEPH E. LOSEE, M.D.