

Application for Fellowship

Head and Neck Oncologic and Reconstructive Surgery Fellowship

Medical University of South Carolina

|  |  |
| --- | --- |
| **Name:**  | **Date:**  |
| **Home Address:**  |
| **Office Telephone:**  | **Cell Phone:****Home Telephone:**  |
| **Social Security Number:**  | **E-Mail Address:**  |
| **Place of Birth:**  | **Date of Birth:**  |
| **Citizenship:**  | **Current Position:**  |

**Name of College or University, Degrees, Date of Graduation**

|  |  |
| --- | --- |
| College |       |
| Degree |       |
| Graduation date |       |

**Name of Medical School, Degree, Date of Graduation**

|  |  |
| --- | --- |
| Medical School |       |
| Degree |       |
| Graduation date |       |

**Name and Location of Hospital, Type of Service, Dates**

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| --- | --- | --- |
| Hospital |       |  |
| Address |       | City       | State       |
| Type of Service |       | Dates       |
|  |       |       |
|  |       |       |

**Name of State, Province or Country, Date License Issued**

|  |  |
| --- | --- |
| State, Province or Country |       |
| License |       |
| Date License Issued |       |

**Name and Location of Institution, Type of Service**

Residency

|  |  |
| --- | --- |
| **Institution** |  |
| **Address** |  | **City**  | **State** |
| **Dates** |  |
|  |  |

Fellowships

|  |  |
| --- | --- |
| **Institution** |  |
| **Address** |  | **City** | **State** |
| **Dates** |  |
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|  |  |
| --- | --- |
| **Institution** |  |
| **Address** |  | **City** | **State** |
| **Dates** |  |
|  |  |

Post-Resident Experience

|  |  |
| --- | --- |
| **Institution** |  |
| **Address** |  | **City** | **State** |
| **Dates** |  |
|  |  |

**Name of Specialty Board and Date**

|  |  |
| --- | --- |
| **Certification** |  |
| **by Board:** |  |
| **Date:** |  |
| **Honors,Awards,Activities** |  |

**Name of Medical or Surgical Societies (attach additional sheets if necessary)**

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| **Medical Society Memberships:** |  |
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**Honors and Awards**

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| --- | --- |
| **Honors** **&** **Awards** |  |
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**Examination and Licensure Scores**

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| --- | --- |
| **Board Exam** **Scores** |  |
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| **Inservice Exam****Scores** |  |
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**Community Service and Volunteer Activities**

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| --- | --- |
| **Community** **Service** |  |
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Personal Statement (please describe your interest in this Fellowship and future goals. Attach additional sheet, if needed)

Contributions to Medical Literature (attach additional sheet, if needed)

Name and address of references (One should be from either your department chairperson or program director).

Please request the letter be sent directly to the address listed.

Reference 1

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  | **City** | **State** |
| **Phone** |  | **e-mail** | **Cell phone**  |

Reference 2

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  | **City** | **State** |
| **Phone** |  | **e-mail** | **Cell phone**  |

Reference 3

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  | **City** | **State** |
| **Phone** |  | **e-mail** | **Cell phone**  |

(2”x2” photo)

I am applying for the following fellowship:

\_\_\_ Head and Neck Oncologic and Reconstructive Fellowship (1 Year Non-Accredited)

\_\_\_ Head and Neck Oncology Research Fellowship (1 Year)

\_\_\_ Head and Neck Oncologic and Reconstructive Observational Fellowship (1 Year Non-Accredited)

I certify that the above is accurate to the best of my knowledge.

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Signature: Date:

**Please return to:**

Terry A. Day, M.D.

Wendy & Keith Wellin Endowed Chair in Head & Neck Surgery

c/o Tanya Byers

Head & Neck Tumor Center

Division of Head and Neck Oncologic Surgery

Department of Otolaryngology - Head and Neck Surgery

135 Rutledge Ave, MSC 550

Charleston, SC 29425-5500

843-792-0719

Email to: byerst@musc.edu

Application Check-List

1. All applications must be typed
2. Updated curriculum vitae attached
3. Please request and have submitted three letters of recommendation.
4. Enclose one 2” x 2” color or b/w photograph. (Optional)