BODY CONTOURING 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 ( )

ATTACH RECENT PHOTOGRAPH

5. CITIZENSHIP
☐ U.S. ☐ OTHER

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

7. MARRIED
☐ YES ☐ NO

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. UNDERGRADUATE 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. 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 BODY CONTOURING 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 BODY CONTOURING FELLOWSHIP WITH ALL OF THE REQUIRED INFORMATION?

- ☐ COMPLETED BODY CONTOURING FELLOWSHIP APPLICATION
- ☐ CURRICULUM VITAE
- ☐ COPY OF USMLE SCORES
- ☐ PERSONAL STATEMENT
- ☐ TWO LETTERS OF RECOMMENDATION, INCLUDING ONE FROM YOUR PROGRAM DIRECTOR

PLEASE MAIL COMPLETED BODY CONTOURING FELLOWSHIP APPLICATION MATERIALS TO:

NINA BEEDLE
BODY CONTOURING FELLOWSHIP COORDINATOR
3550 TERRACE STREET
SCAIFE HALL, SUITE 683
PITTSBURGH, PA 15261
TELEPHONE: 412-383-8082
FAX NUMBER: 412-383-8986
EMAIL: BEEDLEND@UPMC.EDU

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

PROGRAM DIRECTOR: J. PETER RUBIN, M.D.