



Department of Surgery
Division of Orthopaedic Surgery
Duke University Medical Center

*Please provide a
 quality color
 photograph.*

SPORTS MEDICINE SURGERY FELLOWSHIP

(Please print or type)

Name _____ From August 1, _____ To July 31, _____
Last, First, Middle Year Year

Birthdate _____ Social Security Number _____

Birthplace _____ Military Status _____

Citizenship _____ Gender/ Ethnicity _____

Home Address _____ Work Address _____
Street Street

_____ City, State, Zip _____ City, State, Zip

Phone _____ Mobile _____ Phone _____ Pager _____

E-Mail _____ E-Mail _____

ECFMG Number (if applicable) _____ Please attach copy. *(ECFMG J-1 Visa Only for Clinical House Staff)*

Premedical College _____ Degree _____ Dates _____
Month/ Year

Medical School _____ Degree _____ Dates _____
Month/ Year

Residency Training _____ Dates _____
 ACGME Yes or No From/ To

Additional Training _____ Dates _____
 ACGME Yes or No From/ To

Academic Honors, Graduation Rank, etc. _____

Examination Scores, Boards Attach copies of all USMLE/COMLEX/ or equivalent Canadian examinations

References List three physicians whom you should request to send a letter; one should be from your residency training program director.

1. _____
2. _____
3. _____

Curriculum Vitae/Biographical Sketch Please submit a one page summary concerning your background, extracurricular activities, research activities, and career plans.

Transcript Please ask the Dean of your Medical School to send a registered transcript of your academic record to the address below.

Date _____ Signature _____

Please mail to: Dean C. Taylor, M.D., Professor of Orthopaedic Surgery
 Director, Sports Medicine Surgery Fellowship
 c/o Amy Tingen
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 (919) 668-1894 · Email: tinge007@mc.duke.edu