



## **ACFAS STANDARDIZED FELLOWSHIP APPLICATION**

**PLEASE FOLLOW ALL INSTRUCTIONS AS OUTLINED BELOW.**

**APPLICATION DEADLINE FOR THE UPCOMING FELLOWSHIP TRAINING YEAR:  
PLEASE CHECK WITH INDIVIDUAL PROGRAMS FOR THEIR SPECIFIC APPLICATION DEADLINE,  
AS IT VARIES FROM PROGRAM TO PROGRAM.**

### **THE FOLLOWING MATERIALS MUST BE INCLUDED:**

- SIGNED AND COMPLETED APPLICATION
- COPY OF MEDICAL SCHOOL TRANSCRIPT
- VERIFICATION OF MEDICAL SCHOOL GRADUATION: COPY OF DIPLOMA
- VERIFICATION OF ATTENDANCE AT U.S. RESIDENCY PROGRAM: LETTER OF GOOD STANDING FROM DIRECTOR/HOSPITAL
- CURRENT CURRICULUM VITAE
- CURRENT PROFESSIONAL PHOTO
- THREE (3) LETTERS OF RECOMMENDATION AS FOLLOWS:
  - TWO (2) LETTERS OF REFERENCE FROM ATTENDING PHYSICIANS FAMILIAR WITH THE APPLICANT'S PERFORMANCE
  - ONE (1) LETTER FROM THE APPLICANT'S RESIDENCY PROGRAM DIRECTOR

PLEASE FORWARD ALL APPLICATION MATERIALS TO THE APPROPRIATE ACFAS FELLOWSHIP PROGRAM(S) THAT YOU WILL BE APPLYING TO ACCORDING TO THE CONTACT INFORMATION PROVIDED ON THE ACFAS WEBSITE AT:  
<http://www.acfas.org/AvailableFellowships/>

### **DISCLAIMER:**

*THIS FORM IS TO BE USED TO FACILITATE THE APPLICATION PROCESS FOR FELLOWSHIP APPLICANTS, BUT EACH PROGRAM AT THEIR DISCRETION MAY REQUIRE DIFFERENT APPLICATION MATERIALS OR INTERVIEW PROCESSES. ACFAS GRANTS STATUS TO THOSE FELLOWSHIP PROGRAMS WHICH SELF-IDENTIFY AS MEETING SPECIFIC CRITERIA. ACFAS DOES NOT INDEPENDENTLY INVESTIGATE THE FEATURES OF ANY FELLOWSHIP PROGRAM OR WARRANT THE QUALITY OF THE EXPERIENCE.*

### **INSTRUCTIONS:**

PLEASE TYPE OR LEGIBLY PRINT THE INFORMATION REQUESTED IN THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED OR CONSIDERED UNLESS ALL INFORMATION REQUESTED IS RECEIVED, INCLUDING LISTING OF REFERENCES.



**APPLICANT DEMOGRAPHICS:**

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

DRIVER'S LICENSE NO: \_\_\_\_\_ ISSUE STATE/DATE: \_\_\_\_\_ EXPIRATION: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ HOME PHONE: ( ) \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

**APPLICANT EDUCATION:**

UNDERGRADUATE INSTITUTION: \_\_\_\_\_ DEGREE: \_\_\_\_\_

LOCATION: \_\_\_\_\_ DATES ATTENDED: \_\_\_\_\_

GRADUATE INSTITUTION: \_\_\_\_\_ DEGREE: \_\_\_\_\_

LOCATION: \_\_\_\_\_ DATES ATTENDED: \_\_\_\_\_

PODIATRIC MEDICAL SCHOOL: \_\_\_\_\_ DEGREE: \_\_\_\_\_

LOCATION: \_\_\_\_\_ DATES ATTENDED: \_\_\_\_\_

**POST-GRADUATE TRAINING:**

RESIDENCY: \_\_\_\_\_

LOCATION: \_\_\_\_\_ DATES ATTENDED: \_\_\_\_\_

RESIDENCY: \_\_\_\_\_

LOCATION: \_\_\_\_\_ DATES ATTENDED: \_\_\_\_\_

RESIDENCY: \_\_\_\_\_

LOCATION: \_\_\_\_\_ DATES ATTENDED: \_\_\_\_\_



**MEDICAL LICENSES:**

STATE: \_\_\_\_\_ NUMBER: \_\_\_\_\_ ISSUE DATE: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

STATE: \_\_\_\_\_ NUMBER: \_\_\_\_\_ ISSUE DATE: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

**NATIONAL BOARD EXAMINATION RESULTS:**

	PART I	PART II	PART III
DATE TAKEN			
PASS/FAIL			

**REFERENCES:**

RESIDENCY DIRECTOR: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

**LEGAL HISTORY:**

HAS A MEDICAL MALPRACTICE CLAIM/JUDGMENT EVER BEEN FILED/ENTERED AGAINST YOU, OR IS A CLAIM AGAINST YOU SETTLED OR PENDING?

YES                      NO

IF YES, THEN PLEASE EXPLAIN THOROUGHLY ON SEPARATE PIECE OF PAPER.



**WHY DID YOU DECIDE TO APPLY FOR AN ACFAS FELLOWSHIP PROGRAM?**

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**I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND ACCURATE.**

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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