

# APPLICATION FOR PRIMARY CARE SPORTS MEDICINE FELLOWSHIP

NRMP  
2450 N Street, NW, Suite 201  
Washington, DC 20037-1141  
(202)828-0676

To Begin  2004  2005  2006  2007

## PERSONAL DATA:

\_\_\_\_\_  
Last Name First Middle

\_\_\_\_\_  
Present Address

\_\_\_\_\_  
City State Zip/Postal Code Country

\_\_\_\_\_  
Area Code/Telephone Home Work Fax

\_\_\_\_\_  
Permanent Address

\_\_\_\_\_  
City State Zip/Postal Code Country

\_\_\_\_\_  
Area Code/Telephone Home Work Fax

Citizen of U.S.  Yes  No Social Security Number \_\_\_\_\_

Are you aware of any limitation which would prevent you from performing the duties of the fellowship for which you are applying?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EDUCATION:

\_\_\_\_\_  
College or University City/State Dates Degree

\_\_\_\_\_  
College or University City/State Dates Degree

\_\_\_\_\_  
College or University City/State Dates Degree

\_\_\_\_\_  
Advanced Degree School City/State Dates Degree

\_\_\_\_\_  
Advanced Degree School City/State Dates Degree

\_\_\_\_\_  
Medical School City/State Dates Degree (M.D./D.O.)

NATIONAL BOARD OF MEDICAL EXAMINERS SCORES:

I

II

III

\_\_\_\_\_

FLEX SCORES:

I

II

III

\_\_\_\_\_

US MEDICAL LICENSE EXAMINERS:

I

II

III

\_\_\_\_\_

HOSPITAL EXPERIENCE:

PGY-I	HOSPITAL	CITY: _____	DATES (INCLUSIVE)	TYPE
_____	_____	STATE: _____	_____	_____
RESIDENCY	HOSPITAL	CITY: _____	DATES (INCLUSIVE)	TYPE
_____	_____	STATE: _____	_____	_____
RESIDENCY	HOSPITAL	CITY: _____	DATES (INCLUSIVE)	TYPE
_____	_____	STATE: _____	_____	_____
RESIDENCY	HOSPITAL	CITY: _____	DATES (INCLUSIVE)	TYPE
_____	_____	STATE: _____	_____	_____

PREVIOUS PRACTICE EXPERIENCE: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SPORTS MEDICINE ROTATION (Dates, Type, Location, Instructor):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SPORTS MEDICINE COVERAGE (Games, Events, Training Room, Other):

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SPORTS MEDICINE CONFERENCES:

Attended: \_\_\_\_\_  
\_\_\_\_\_

Presented: \_\_\_\_\_  
\_\_\_\_\_

ADDITIONAL PERSONAL DATA:

1. Work Experience Prior to Medical Training (Occupational/Title, Dates):

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2. Military Status (U.S.A.) (Present Status and Service):

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a. Do you hold a Reserve commission?  Yes  No

To begin \_\_\_\_\_ for \_\_\_\_\_ on \_\_\_\_\_

Branch: \_\_\_\_\_

Rank: \_\_\_\_\_

b. Have you served in the military or U.S.P.H.S.?  Yes  No

Have you attended summer training camp?  Yes  No

c. Are you required to attend reserve meetings?  Yes  No

Are you required to attend summer training camp?  Yes  No

d. Do you have a military or U.S.P.H.S. commitment?  Yes  No

To begin on \_\_\_\_\_ for \_\_\_\_\_

3. Are you certified by the E.C.F.M.G.?  Yes  No

Which qualifying exam taken? \_\_\_\_\_

a. Date passed: \_\_\_\_\_

b. Scores: Part I: \_\_\_\_\_  
Part II: \_\_\_\_\_

c. Certificate number: \_\_\_\_\_

d. Certificate valid through what date: \_\_\_\_\_

4. If not a U.S. Citizen, will you enter or remain in the U.S. on:

a. Exchange Visitor Visa: \_\_\_\_\_

b. Permanent Visa Number: \_\_\_\_\_

c. How many years may you remain in the U.S.A.? \_\_\_\_\_

5. Publications (author, title, publication, date - use additional sheets if necessary): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Conferences Attended or Presented (other than sports medicine): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Honors and Awards: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. References and Supporting Documents:

\*Please ask three physicians who have supervised you in a clinical setting to send letters in support of your application.

\*Copies of the following documents are requested: medical school diploma, certificate for other validation of all previous training, copy of present state medical licenses, and curriculum vitae.

\*Please note that individual fellowships may require additional information such as (but not limited to ) letter of commendation from medical school dean, undergraduate and medical school transcripts, and rotations taken during residency.

9. Personal Statement:

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Personal Statement Continued:

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DO NOT SEND ORIGINAL DOCUMENTS. NO DOCUMENTS WILL BE RETURNED.

PHOTOCOPIES OF THIS APPLICATION WILL BE ACCEPTED. HOWEVER THE SIGNATURE ON EACH APPLICATION MUST BE ORIGINAL

I certify that the information given or attached is true, accurate and complete.

Signature \_\_\_\_\_  
(must be original)

Date \_\_\_\_\_

PLEASE SEND ALL APPLICATIONS AND SUPPORTING DOCUMENTS TO THE PRIMARY CARE SPORTS MEDICINE FELLOWSHIPS TO WHICH YOU ARE APPLYING.

DO NOT return application the American Medical Society for Sports Medicine.