

PEDIATRIC CLEFT, CRANIOFACIAL, AND SPECIAL NEEDS FELLOWSHIP TRAINING APPLICATION

Department of Plastic Surgery

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL AFFILIATED HOSPITALS

Children's Medical Center & University Hospitals

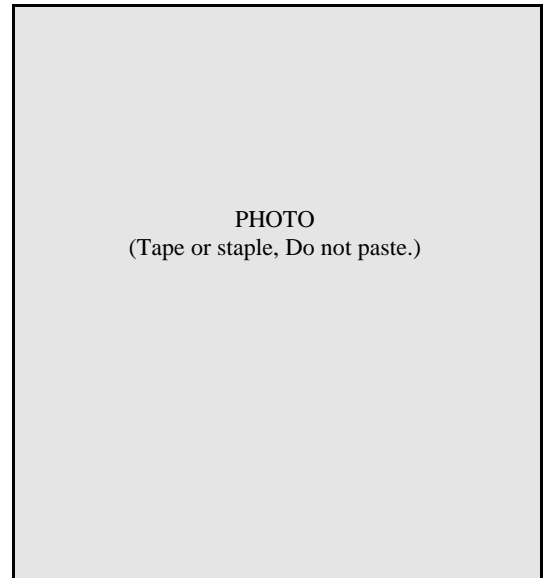
Please return one copy of application to:

Kaydance Hope
 Pediatric Cleft, Craniofacial, and Special Needs Fellowship Training Administrator
 Department of Plastic Surgery
 The University of Texas Southwestern Medical Center
 1800 Inwood Rd./WA4.226
 Dallas, Texas 75390-9132

Telephone inquiries: (214) 645-3104

ADDITIONAL REQUIREMENTS:

- ⊘ Transcript of Dental school grades
- ⊘ Letter from Dean of Dental school evaluating your performance
- ⊘ Two letters of recommendation from Dentists who have knowledge of your clinical ability
- ⊘ CV
- ⊘ Copies of any residencies or fellowships or (a letter on official letterhead from your current program director stating that you are in good standing and your expected graduation date)
- ⊘ Dental School Diploma
- ⊘ ECFMG Certificate (if applicable)



Beginning Date of Residency:	Sex: ~ M ~ F
Name:	Date of Birth:
Present Address:	Present Telephone:
	SSN:
Nearest Relative (not living with you) Address: Telephone:	Marital Status: Spouse's Name:
Military Status:	Country of Citizenship:
Do you have a Texas Medical License:	If so, number:

PRE-MEDICAL/DENTAL EDUCATION

Name of Institution	City & State	From Mo-Yr.	To Mo-Yr	Degree/ Major	Honors
College					
Graduate School					

MEDICAL/DENTAL EDUCATION

Name of Institution	City & State	From Mo-Yr.	To Mo-Yr	Degree	Honors

Estimate Scholastic Standing in your Class: Lower 1/3 Middle 1/3 Upper 1/3 Upper 10%

National Board Scores :

INTERNSHIP OR RESIDENCY TRAINING

Please list anticipated prerequisite training prior to plastic surgery residency. Indicate with "your current level of training".

SPECIALTY	INSTITUTION	FROM Mo-Yr	TO Mo-Yr
PGY 1			
PGY 2			
PGY 3			
PGY 4			
PGY 5			
PGY 6			
PGY 7			

Foreign Graduates or Non-Citizens, please complete the following:

Have you passed the ECFMG exam? _____ VQE exam? _____ If so, please send copy of certificate/letter*
 Visa Status _____ Please send copy of visa*

*notarized as a true copy of original document

If applicable, please send copy of Fifth Pathway letter

LIST THOSE WRITING LETTERS OF RECOMMENDATION (name, address, position):

- 1.
- 2.
- 3.

Signature: _____

Date: _____

GOAL STATEMENT

(additional information may be attached)

1. Describe your interest in Pediatric Cleft, Craniofacial, and Special Needs surgery, as well as, future goals and plans.

2. Describe the ideal training program for you and why?

3. What is your strongest attribute that will make you an excellent Pediatric Cleft, Craniofacial, and Special Needs surgeon?

a) Which personality trait do you desire to improve the most?

b) How are you attempting to improve this characteristic?

STATEMENT OF APPLICANT

Please read before signing this application

I understand and acknowledge that, as an applicant for appointment to the University of Texas Southwestern Medical Center at Dallas (UTSWMCD) Pediatric Cleft, Craniofacial, and Special Needs Fellowship Program, it is my responsibility to provide sufficient information upon which a proper evaluation of my qualifications including my current licensure, relevant training and/or experience, current competence, character and ethics can be based.

I further understand and acknowledge that UTSWCD Pediatric Cleft, Craniofacial, and Special Needs Fellowship, will verify the information in this application. By submitting this application, I agree to such verification of information. I also understand and acknowledge that completing this application does not entitle me to entrance into UTSWCD Pediatric Cleft, Craniofacial, and Special Needs Fellowship.

1. **Verification of Application:** I hereby authorize all individuals, institutions and entities, (past, present and future) including all professional liability insurers with which I have had or currently have professional liability insurance, who have knowledge concerning my qualification and other information requested in this application, to consult with and release relevant information and records to UTSWCD Pediatric Cleft, Craniofacial, and Special Needs Fellowship.
2. **Authorization of Release:** I understand and agree that the authorizations given by me herein shall be irrevocable for a period of twenty-four (24) months. A photocopy of this waiver shall be as effective as the original when so presented.

All information provided by me in this application is true to the best of my knowledge and belief. I understand and agree that any material misstated in or omission from this application may constitute grounds for denial of appointment or for summary dismissal from UTSWCD Pediatric Cleft, Craniofacial, and Special Needs Fellowship. I further acknowledge that I have read and understand the foregoing authorization. I hereby also release from liability all representatives of UTSWCD Pediatric Cleft, Craniofacial, and Special Needs Fellowship, and release all medical schools, licensing boards, specialty societies and all other entities and individuals providing information from liability for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented to above.

I agree to notify UTSWCD Pediatric Cleft, Craniofacial, and Special Needs Fellowship of any circumstances arising subsequent to the date of this application which would change any of the responses I have given in this application.

I agree to notify the administrators of UTSWCD Pediatric Cleft, Craniofacial, and Special Needs Fellowship within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against me.

Name _____

Date _____

Signature _____

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