

SSO BREAST FELLOWSHIP APPLICATION

Please submit this completed form to those institutions to which you are interested in applying. Photocopies are acceptable.

PLEASE ALSO SEND A COPY OF THIS FORM TO THE SSO EXECUTIVE OFFICE.

To participate in the SSO Fellowship Matching Program, you must also submit the SSO Matching Program Application Form to SSO's Executive Office by the date indicated on the instructions.

IDENTIFYING INFORMATION

Last Name:				First:		Middle:	
Home Mailing Address: ()		City:		State:		Zip:	
Home Telephone Number:			Email Address:				
Work Mailing Address: ()		City: ()		State:		Zip:	
Work Telephone Number:			Fax Number:				
Birthdate:			Birth Place (City/State/Country):				
Citizenship:			Visa (if not US citizen):				
Social Security Number:			ECFMG#:				
Marital Status:			Spouse's Name:				
Outside Interests & Hobbies:							

PRE-MEDICAL EDUCATION

College or University Name:		Degree Received:		Date of Graduation:			
Mailing Address:		City:		State:		Zip:	
College or University Name:		Degree Received:		Date of Graduation:			
Mailing Address:		City:		State:		Zip:	

P O S T G R A D U A T E E D U C A T I O N

College or University Name:

Degree Received:

Date of Graduation:

Mailing Address:

City:

State:

Zip:

College or University Name:

Degree Received:

Date of Graduation:

Mailing Address:

City:

State:

Zip:

R E S I D E N C I E S / F E L L O W S H I P S

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and zip code, and dates. Include all programs you attended, whether or not completed.

Institution:

Program Director:

Mailing Address:

City:

State:

Zip:

Type of Training (eg., residency, etc):

Specialty:

From:

To:

Did you successfully complete the program? Yes No (If "no", please explain)

Institution:

Program Director:

Mailing Address:

City:

State:

Zip:

Type of Training (eg., residency, etc):

Specialty:

From:

To:

Did you successfully complete the program? Yes No (If "no", please explain)

Institution:

Program Director:

Mailing Address:

City:

State:

Zip:

Type of Training (eg., residency, etc):

Specialty:

From:

To:

Did you successfully complete the program? Yes No (If "no", please explain)

S P E C I A L T Y

I am a:

Surgeon

Medical Oncologist

Radiation Oncologist

Gynecologist

P E E R R E F E R E N C E S

List three professional references, preferably from your surgical faculty or research faculty that you have worked with during your training. NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

()

Name of Reference: _____ Specialty: _____ Telephone Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

()

Name of Reference: _____ Specialty: _____ Telephone Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

()

Name of Reference: _____ Specialty: _____ Telephone Number: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

O T H E R

Board Certification: _____ Yes No Date of Board Certification _____

License Number: _____ State: _____ Exp: _____

Honors & Awards:

Absite Scores (List as percentile): _____ 1st year _____ 2nd year _____ 3rd year _____ 4th year

Have you taken USMLE Step III? Yes No Not Required

If yes, Date: _____ Numerical Score _____ Pass Fail (circle one)

If USMLE Step III is not required, please explain:

P R O F E S S I O N A L L I A B I L I T Y

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?

Yes

No

If yes, please provide list and status on a separate sheet.

D I S C I P L I N A R Y A C T I O N S

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide full explanation on a separate sheet.

- Medical license in any state Yes ___ No ___
- Other professional registration/license Yes ___ No ___
- DEA registration Yes ___ No ___
- Academic appointment Yes ___ No ___
- Membership on any hospital medical staff Yes ___ No ___
- Clinical privileges Yes ___ No ___
- Prerogative/rights on any medical staff Yes ___ No ___
- Other institutional affiliation or status threat Yes ___ No ___
- Professional society membership or fellowship/Board certification Yes ___ No ___
- Professional office Yes ___ No ___
- Any other type of professional sanction Yes ___ No ___
- Professional liability insurance Yes ___ No ___
- Have there been any felony criminal charges brought against you in the last five years Yes ___ No ___
- Have you been convicted of any crimes Yes ___ No ___

H E A L T H S T A T U S

(If any of these questions are answered in the affirmative, please provide full explanation on a separate sheet.)

- Do you presently have a physical or mental health condition, including Alcohol or drug dependence, that affects or is reasonably likely to affect Your ability to perform professional or medical duties appropriately? Yes ___ No ___
- Are you currently under care for a continuing health problem? Yes ___ No ___
- Have you at any time during the last five years been hospitalized or Received any other type of institutional care for a health problem? Yes ___ No ___

Comment:

S I G N A T U R E

I hereby certify that to the best of my knowledge and belief, I have no physical or mental illness or mental defect which interferes with my professional appointment. All information submitted by me in this application is true and accurate to my best knowledge and belief. **(Please enclose a photo (optional)).**

Signature:

Date:

Please submit this completed form to those institutions to which you are interested in applying. Photocopies are acceptable.

PLEASE ALSO SEND A COPY OF THIS FORM TO THE SSO EXECUTIVE OFFICE.

Society of Surgical Oncology
85 W. Algonquin Road, Suite 550
Arlington Heights, IL 60005