

# SSO General Surgical Oncology 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.

## I D E N T I F Y I N G   I N F O R M A T I O N

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#:		
Outside Interests & Hobbies:			

## P R E - M E D I C A L   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:

## 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:

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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)

## 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