UNC-CH Primary Care Sports Medicine Fellowship
Visiting Resident Rotation Application Form

Please complete the form below and attach a current CV, a letter of good standing from your residency program director, and medical liability coverage confirmation. Please email all forms to Ashley Heidinger at smfellow@med.unc.edu.

PERSONAL DATA

Full Name: ____
Last First Middle

Mailing Address:

____
Street Address

____
City State Zip Code

Telephone:
Home ( ) _______________ Work ( ) ________________Cell ( ) ________________

Email: ____

US CITIZEN: YES_____ NO_____

If not a citizen:

- PERMANENT RESIDENT___
- J-1____
- H-1 ___
- OTHER (please specify) ____

EDUCATION

<u>Undergraduate Education</u>

_________________________________ _________________________________
Institution Name Institution City/State

Attended From __________ To __________ Degree awarded: ___________________________

<u>Graduate Education</u> <u>(Medical and Masters or Doctoral Program)</u>

_________________________________ _________________________________
Institution Name Institution City/State

Attended From __________ To __________ Degree awarded: ___________________________

_________________________________ _________________________________
Institution Name Institution City/State

Attended From __________ To __________ Degree awarded: ___________________________

Postgraduate Medical Education:

Internship: (if more than one, please provide additional information on a separate sheet)

____

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

Residencies: (if more than one, please provide additional information on a separate sheet)

____

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

Fellowships: (if more than one, please provide additional information on a separate sheet)

____

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

LICENSE INFORMATION/CERTIFICATION

USMLE Step I __________ ________________
(Date) (Scores)

USMLE Step II __________ _________________
(Date) (Scores)

USMLE Step III __________ _________________
(Date) (Scores)

COMLEX
(for DO training)

Level I __________ Level II ___________ Level III __________
(Score) (Score) (Score)

ECFMG number /date (if applicable) _________________________

Board Certified? If "yes" enter name of Board and Year Certified ________________________________

LICENSURE:
State ________ Number _________ Date ____________ Type ________ Expiration ______

ROTATION PREFERENCE

Please list in order of preference your top 3 rotation months. Requests are strongly considered but not guaranteed. Rotations are offered during the last two weeks of each month except in May, June, July, November, and December.

Preference #1________________ Preference #2________________ Preference #3________________

STATEMENT OF INTEREST (200-word limit)

Please describe your interest in the Primary Care Sports Medicine visiting resident rotation at UNC Chapel Hill and indicate whether you will be applying to a Primary Care Sports Medicine fellowship in the future.