

California Pacific Shoulder Surgery Fellowship

3000 California Street, San Francisco, CA 94115

(415) 563 2600

Eugene M. Wolf, M.D.

Arthroscopy

Application for Post-Residency Education in the Shoulder

The shoulder program is for a period of 12 months to begin _____

Date _____

1. Name in full (not initials) _____ Age _____

2. Present Address _____
First Middle Last
Street City State Zip Code

3. Permanent Address _____

4. Phone Number _____ Social Security # _____
Home Office

6. Birthplace _____ Birthdate _____

7. Citizenship _____

If alien, date of entry _____ Type of Visa _____

Expiration date _____ Passed ECFMG Exam _____

8. Marital Status _____ Spouse's Name _____

9. Names of institutions of education:

(a) College _____ 19__ to 19__ Degree: _____
name major field

(b) College _____ 19__ to 19__ Degree: _____
name major field

Academic standing in college _____

Honors, prizes, scholarships, memberships in honorary societies, non-academic achievements, Extracurricular and civic activities:

(b) Medical School _____ 19__ to 19__ Degree _____
name city

_____ 19__ to 19__ Degree _____
name city

Honors (prizes, scholarships, memberships in honorary societies) non-academic achievements:

Academic standing in Medical School _____

(c) Graduate School _____
name and location

Date _____ Degree, if any _____

Major field _____

(d) Internship: Rotating ___ Mixed ___ Straight in _____
field

_____ from _____ to _____
hospital city state

(e) Post graduate Education (list residency programs):

1st year _____ from _____ to _____.
month/year month/year

2nd year _____ from _____ to _____.
month/year month/year

3rd year _____ from _____ to _____.
month/year month/year

4th year _____ from _____ to _____.
month/year month/year

5th year _____ from _____ to _____.
month/year month/year

(f) Additional education or fellowship:

1. Type: _____ from _____ to _____.
month/year month/year

Name of Director and location _____

Activity During fellowship _____

10. Professional practice, place and dates _____

11. Future plans or arrangements for full time academic career in Orthopaedics:

(a) Institution of matriculation _____

(b) Location _____

(c) Starting date _____

(d) Name of chairman _____

12. Medical licensure (states) _____

National Board: Part I ___ Part II ___ Part III ___ Flex: Part I ___ Part II ___

13. Military service (give dates and rank) _____

Training _____

Do you hold a reserve commission? ___ If so, what rank? _____

14. What foreign language do you read or write with facility? _____

15. Present recreational interest and hobbies _____

16. State of health _____ Height _____ Weight _____

17. Do you have any physical, emotional, or medical disability that would preclude you from performing your duties if you are appointed? Yes _____ No _____

If yes, please give details: _____

18. Do you have any defects of sight, hearing, speech or limb? If so, what? _____

19. Do you have any medical or surgical condition which might be considered significant? If so, what? _____

20. List of documents to be sent in support of this application:

1. Recent photograph (approximately 2" x 3")
2. Letter of recommendation from the chief of your Orthopaedic Residency Program.
3. CV listing teaching experience, research projects, and publications.

21. While a personal interview is not mandatory, it is desirable so that the applicant can visit the hospital and staff.