Children's Hospital of Pittsburgh of UPMC

CLEFT / CRANIOFACIAL FELLOWSHIP APPLICATION

DEMOGRAPHICS

Last Name:	First Name:	Middle Initial:	Attach Recent Photograph
Current Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:		
Email Address:			

Citizenship: U.S. ☐ Other: ☐ Married: ☐ Yes ☐ No	Visa Status (if Applicable) ☐ Permanent ☐ J-1 ☐ Temporary ☐ H-1B	ECFMG Certificate No: (if applicable)

MEDICAL EDUCATION

Medical School (#1):		
City:	State:	Country:
Medical School (#2):		
City:	State:	Country:

GRADUATE EDUCATION

Graduate School:	Dates Attended:	Graduate Degree:
City:	State:	Country:
Graduate School:	Dates Attended:	Graduate Degree:
City:	State:	Country:

UNDERGRADUATE EDUCATION

Undergraduate School:	Dates Attended:	Graduate Degree:
City:	State:	Country:
Undergraduate School:	Dates Attended:	Graduate Degree:
City:	State:	Country:

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RESIDENCY / FELLOWSHIP EDUCATION

Residency Program (#1):		Dates Attended:
Program Director:		
City:	State:	Country:
Residency Program (#2):		Dates Attended:
Program Director:		
City:	State:	Country:
Residency Program (#3):		Dates Attended:
Program Director:		
City:	State:	Country:
Fellowship Program (#1):		Dates Attended:
Fellowship Director:		
City:	State:	Country:
Fellowship Program (#2):		Dates Attended:
Fellowship Director:		
City:	State:	Country:

USMLE SCORES

☐	USMLE Step I (Date Taken):	Score:
☐	USMLE Step II (Date Taken):	Score:
☐	USMLE Step III (Date Taken):	Score:

BOARD CERTIFICATIONS

Specialty:	Date:	Certificate No:
Specialty:	Date:	Certificate No:

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LETTERS OF RECOMMENDATION	
#1 Program Director Name:	
Institution:	
Address:	
Address:	
#2 Name and Title:	
Institution:	
Address:	
Address:	
#3 Name and Title:	
Institution:	
Address:	
Address:	
☐ I Hereby waive access to the above letters and will so inform the authors.	
☐ I desire access to the above letters and will so inform the authors.	
Name of Applicant:	Signature and Date:

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PERSONAL STATEMENT

Please provide a personal statement detailing your interest and intentions regarding Craniofacial Surgery.

I certify that the information submitted on these application materials is complete and correct to the best of my knowledge, I understand that any false or missing information may disqualify me for this position.

Signature of Applicant:	Date:

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APPLICATION CHECKLIST

Have you provided the Craniofacial Fellowship with all of the required information?

- ☐ Completed Craniofacial Fellowship Application
- ☐ Curriculum Vitae
- ☐ Copy of USMLE Scores
- ☐ Personal Statement
- ☐ Three letters of recommendation, including one from your Plastic Surgery Program Director

Please mail completed Craniofacial Fellowship Application Materials to:

Antoinette Vamos
Craniofacial Fellowship Coordinator
Children's Hospital of Pittsburgh of UPMC
4401 Penn Avenue, Faculty Pavilion, Suite 7104
Pittsburgh, PA 15224
Phone: 412-692-7949
Fax: 412-692-5263
E-mail: antoinette.vamos@chp.edu

If you have any questions regarding the Craniofacial Fellowship, please feel free to call or send an e-mail request to: Antoinette Vamos.

Fellowship Director: Joseph E. Losee, MD