American College of
Foot and Ankle Surgeons®
Proven leaders. Lifelong learners. Changing lives.

8725 West Higgins Road
Suite 555
Chicago, Illinois 60631-2724

info@acfas.org
773-693-9300 *phone*
773-693-9304 *fax*
acfas.org
FootHealthFacts.org

ACFAS STANDARDIZED FELLOWSHIP APPLICATION

PLEASE FOLLOW ALL INSTRUCTIONS AS OUTLINED BELOW.

**APPLICATION DEADLINE FOR THE UPCOMING FELLOWSHIP TRAINING YEAR:
PLEASE CHECK WITH INDIVIDUAL PROGRAMS FOR THEIR SPECIFIC APPLICATION DEADLINE,
AS IT VARIES FROM PROGRAM TO PROGRAM.**

THE FOLLOWING MATERIALS MUST BE INCLUDED:

- ☐ SIGNED AND COMPLETED APPLICATION
- ☐ COPY OF MEDICAL SCHOOL TRANSCRIPT
- ☐ VERIFICATION OF MEDICAL SCHOOL GRADUATION: COPY OF DIPLOMA
- ☐ VERIFICATION OF ATTENDANCE AT U.S. RESIDENCY PROGRAM: LETTER OF GOOD STANDING FROM DIRECTOR/HOSPITAL
- ☐ CURRENT CURRICULUM VITAE
- ☐ CURRENT PROFESSIONAL PHOTO
- ☐ THREE (3) LETTERS OF RECOMMENDATION AS FOLLOWS:
  - TWO (2) LETTERS OF REFERENCE FROM ATTENDING PHYSICIANS FAMILIAR WITH THE APPLICANT'S PERFORMANCE
  - ONE (1) LETTER FROM THE APPLICANT'S RESIDENCY PROGRAM DIRECTOR

PLEASE FORWARD ALL APPLICATION MATERIALS TO THE APPROPRIATE ACFAS FELLOWSHIP PROGRAM(S) THAT YOU WILL BE APPLYING TO ACCORDING TO THE CONTACT INFORMATION PROVIDED ON THE ACFAS WEBSITE AT: www.acfas.org/fellowshiplisting

DISCLAIMER:
THIS FORM IS TO BE USED TO FACILITATE THE APPLICATION PROCESS FOR FELLOWSHIP APPLICANTS, BUT EACH PROGRAM AT THEIR DISCRETION MAY REQUIRE DIFFERENT APPLICATION MATERIALS OR INTERVIEW PROCESSES. ACFAS GRANTS STATUS TO THOSE FELLOWSHIP PROGRAMS WHICH SELF-IDENTIFY AS MEETING SPECIFIC CRITERIA. ACFAS DOES NOT INDEPENDENTLY INVESTIGATE THE FEATURES OF ANY FELLOWSHIP PROGRAM OR WARRANT THE QUALITY OF THE EXPERIENCE.

INSTRUCTIONS:
PLEASE TYPE OR LEGIBLY PRINT THE INFORMATION REQUESTED IN THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED OR CONSIDERED UNLESS ALL INFORMATION REQUESTED IS RECEIVED, INCLUDING LISTING OF REFERENCES.

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APPLICANT DEMOGRAPHICS:

NAME: _____ TODAY'S DATE:_____

DATE OF BIRTH: _____ PLACE OF BIRTH:_____

DRIVER'S LICENSE NO:_____ ISSUE STATE/DATE:_____ EXPIRATION:_____

HOME ADDRESS: _____ HOME PHONE: ( )_____

WORK ADDRESS: _____ WORK PHONE: ( )_____

E-MAIL ADDRESS: _____ FAX: ( )_____

APPLICANT EDUCATION:

UNDERGRADUATE INSTITUTION: _____ DEGREE: _____

LOCATION: _____ DATES ATTENDED: _____

GRADUATE INSTITUTION: _____ DEGREE: _____

LOCATION: _____ DATES ATTENDED: _____

PODIATRIC MEDICAL SCHOOL: _____ DEGREE: _____

LOCATION: _____ DATES ATTENDED: _____

POST-GRADUATE TRAINING:

RESIDENCY: _____

LOCATION: _____ DATES ATTENDED: _____

RESIDENCY: _____

LOCATION: _____ DATES ATTENDED: _____

RESIDENCY: _____

LOCATION: _____ DATES ATTENDED: _____

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MEDICAL LICENSES:

STATE: _____ NUMBER: _____ ISSUE DATE: _____EXP DATE: _____

STATE: _____ NUMBER: _____ ISSUE DATE: _____EXP DATE: _____

NATIONAL BOARD EXAMINATION RESULTS:

	PART I	PART II	PART III
DATE TAKEN			
PASS/FAIL			

REFERENCES:

RESIDENCY DIRECTOR: _____

WORK ADDRESS: _____

PHONE: _____

NAME: _____

WORK ADDRESS: _____

PHONE: _____

NAME: _____

WORK ADDRESS: _____

PHONE: _____

LEGAL HISTORY:

HAS A MEDICAL MALPRACTICE CLAIM/JUDGMENT EVER BEEN FILED/ENTERED AGAINST YOU, OR IS A CLAIM AGAINST YOU SETTLED OR PENDING?

YES ◯ NO ◯

IF YES, THEN PLEASE EXPLAIN THOROUGHLY ON SEPARATE PIECE OF PAPER.

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WHY DID YOU DECIDE TO APPLY FOR AN ACFAS FELLOWSHIP PROGRAM?

_____

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I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND ACCURATE.

_____
PRINT NAME

_____ _____
SIGNATURE DATE

PLEASE FORWARD ALL APPLICATION MATERIALS TO
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