

International Scholars Program

Application must be typewritten and in English. Fields with an asterisk * are required. If you have nothing to put in required fields, please write N/A.

*First name: _____ Middle name: _____

*Last name: _____

*Address: _____

*City: _____ State/Province: _____

*Postal code: _____ *Country: _____

*Phone: _____ Fax: _____

*Email: _____

Place of birth: _____ *Citizenship: _____

*Date of birth: _____ *Gender: Male Female

Licensure

Please indicate information about your license to practice surgery. Enter at least one.

Name of state, province, or country:

License type: Full Restricted

License number: _____ Date originally issued: _____

Name of state, province, or country:

License type: Full Restricted

License number: _____ Date originally issued: _____

Area of practice

Indicate your specialties along with the amount of time you dedicate to each area listed. Enter at least one.

Specialty: _____ **Percentage of time in specialty: _____

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***Enter as a whole number, i.e. 25 means 25 percent.*

Academic appointments

Where do you teach and hold an academic appointment? Enter at least one.

Name of medical school:

Faculty position and department: _____

From (mm/yyyy): _____ To (mm/yyyy): _____

Name of medical school: _____

Faculty position and department: _____

From (mm/yyyy): _____ To (mm/yyyy): _____

Certification by specialty boards

Enter at least one or indicate not applicable.

Name of specialty board: _____

Date of certification (mm/yyyy): _____ Certification number: _____

Name of specialty board: _____

Date of certification (mm/yyyy): _____ Certification number: _____

Other college fellowship or certification (i.e.: Royal College of Surgeons, etc.)

Name: _____

Name: _____

Pre-medical education

Enter at least one.

Name of college or university: _____ Location: _____

Degree(s): _____ Graduation date: _____

From (mm/yyyy): _____ To (mm/yyyy): _____

Name of college or university: _____ Location: _____

Degree(s): _____ Graduation date: _____

From (mm/yyyy): _____ To (mm/yyyy): _____

Medical school

*From what medical school did you graduate?

Name of medical school: _____

Location: _____ Degree: _____

Graduation date: _____ From (mm/yyyy): _____ To (mm/yyyy): _____

Letters of recommendation

Applicants are required to submit letters of recommendations from no more than three of their colleagues. One letter of recommendation must be from the chair of the department in which they hold an academic appointment or a member of the Society for Vascular Surgery who resides in the applicant's country. The Chair's or the member's letter must include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant.

Questions?

Please contact Susan Burkhardt at 312-334-2310 or by email at sburkhardt@vascularsociety.org if you have questions.