THE HIP SOCIETY

6300 N. River Road, Suite 727 • Rosemont, IL 60018- 4226 • Phone (847)698-1638 • Fax (847)823-0536
Email: hip@aaos.org • Website: www.hipsoc.org

EUROPEAN FELLOWSHIP IN HIP RECONSTRUCTION

SPONSORED BY THE MAURICE E. MÜLLER FOUNDATION OF NORTH AMERICA

APPLICATION FORM

NAME: _____

BIRTHDATE: **(M)** _____ **(D)** _____ **(Y)** _____

PRESENT ADDRESS: _____

_____

_____

_____

TELEPHONE: **( )** _____

FAX: **( )** _____

E-MAIL ADDRESS: _____

PERMANENT ADDRESS: _____
(if different from above)

_____

_____

_____

TELEPHONE: **( )** _____

NAME OF SPOUSE/PARTNER: _____

NUMBER OF CHILDREN: (Include name and age)

_____ _____

EDUCATION

COLLEGE/UNIVERSITY: _____

DATES ATTENDED: _____**TO** _____

MAJOR FIELD: _____

DEGREE: _____

HONORS: _____

_____

(If applicable)
GRADUATE SCHOOL (OTHER THAN MEDICAL SCHOOL)

COLLEGE/UNIVERSITY _____

DATES ATTENDED: _____**TO** _____

DEGREE: _____

HONORS: _____

MEDICAL SCHOOL: _____

DATES ATTENDED: _____**TO** _____

HONORS: _____

_____

PROPOSED LOCATION(S) OF STUDY AND DURATION OF STAY

LOCATION NO. 1

INSTITUTION: _____

CITY AND COUNTRY: _____

LENGTH OF STAY: _____

PRECEPTOR: _____

LOCATION NO. 2 (If applicable)

INSTIUTION: _____

CITY AND COUNTRY: _____

LENGTH OF STAY: _____
PRECEPTOR: _____

CAREER PLANS AND REASON FOR SEEKING FELLOWSHIP:

(Attach 100-200 word statements of career goals etc)

REFERENCES:

FROM THE FOLLOWING:

- **CHIEF OF ORTHOPAEDIC RESIDENCY PROGRAM:**

  NAME: _____

  ADDRESS: _____

  _____

  _____

TELEPHONE: **( )** _____

E-MAIL ADDRESS: _____

- **TWO OTHER ACADEMIC ORTHOPAEDIC REFERENCES:**

  NAME: _____

  ADDRESS: _____

  _____

  _____

TELEPHONE: **( )** _____

E-MAIL ADDRESS: _____

  NAME: _____

  ADDRESS: _____

  _____

  _____

TELEPHONE: **( )** _____

E-MAIL ADDRESS: _____

All applications and supporting letters must be received by December 1st, 2 years preceding the desired start of the Fellowship. Fellowships will normally start in August.

PERSONAL INFORMATION

ORTHOPAEDIC TRAINING (Include place and dates)

_____

_____

_____

_____

_____

FELLOWSHIP TRAINING (1):

TYPE: _____

LOCATION: _____

DATES: _____**TO** _____

FELLOWSHIP TRAINING (2):

TYPE: _____

LOCATION: _____

DATES: _____**TO** _____

RESEARCH EXPERIENCE (Include place and dates)

_____

_____

_____

ATTACH A SEPARATE SHEET, IF NECESSARY, FOR THE FOLLOWING:

- **PUBLICATIONS**
- **PRESENTATIONS AT NATIONAL MEETING**

OUTSIDE INTERESTS:

_____

_____

_____

_____

Please send completed application with all necessary materials to BOTH:

Robert T. Trousdale, MD
Attn: European Fellowship Application
Mayo Clinic
200 First St SW
Rochester, MN 55905

and

The Hip Society
Attn: European Fellowship Application
6300 N. River Road, Suite 727
Rosemont, IL 60018- 4226

Questions – Please contact Dr. Trousdale at (507)284-3663 or email Trousdale.robert@mayo.edu or the Hip Society administrative office at (847)698-1638.