

# SSO General Surgical Oncology Fellowship Application

*Please submit this completed form to those institutions to which you are interested in applying. Photocopies are acceptable.*

**PLEASE ALSO SEND A COPY OF THIS FORM TO THE SSO EXECUTIVE OFFICE.**

To participate in the SSO Fellowship Matching Program, you must also submit the SSO Matching Program Application Form to SSO's Executive Office by the date indicated.

## I D E N T I F Y I N G   I N F O R M A T I O N

Last Name:	First:	Middle:	
Home Mailing Address: (     )	City:	State:	Zip:
Home Telephone Number:	Email Address:		
Work Mailing Address: (     )	City: (     )	State:	Zip:
Work Telephone Number:	Fax Number:		
Birthdate:	Birth Place (City/State/Country):		
Citizenship:	Visa (if not US citizen):		
Social Security Number:	ECFMG#:		
Outside Interests & Hobbies:			

## P R E - M E D I C A L   E D U C A T I O N

College or University Name:	Degree Received:	Date of Graduation:	
Mailing Address:	City:	State:	Zip:
College or University Name:	Degree Received:	Date of Graduation:	
Mailing Address:	City:	State:	Zip:

## P O S T G R A D U A T E E D U C A T I O N

College or University Name:

Degree Received:

Date of Graduation:

Mailing Address:

City:

State:

Zip:

College or University Name:

Degree Received:

Date of Graduation:

Mailing Address:

City:

State:

Zip:

## R E S I D E N C I E S / F E L L O W S H I P S

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and zip code, and dates. Include all programs you attended, whether or not completed.

Institution:

Program Director:

Mailing Address:

City:

State:

Zip:

Type of Training (eg., residency, etc):

Specialty:

From:

To:

Did you successfully complete the program?  Yes  No (If "no", please explain)

Institution:

Program Director:

Mailing Address:

City:

State:

Zip:

Type of Training (eg., residency, etc):

Specialty:

From:

To:

Did you successfully complete the program?  Yes  No (If "no", please explain)

Institution:

Program Director:

Mailing Address:

City:

State:

Zip:

Type of Training (eg., residency, etc):

Specialty:

From:

To:

Did you successfully complete the program?  Yes  No (If "no", please explain)

## P E E R R E F E R E N C E S

List three professional references, preferably from your surgical faculty or research faculty that you have worked with during your training. NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

(     )

Name of Reference: \_\_\_\_\_ Specialty: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(     )

Name of Reference: \_\_\_\_\_ Specialty: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(     )

Name of Reference: \_\_\_\_\_ Specialty: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## O T H E R

Board Certification: \_\_\_\_\_ Yes     \_\_\_ No     Date of Board Certification \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_ Exp: \_\_\_\_\_

Honors & Awards:

Absite Scores (List as percentile):     \_\_\_ 1st year     \_\_\_ 2nd year     \_\_\_ 3rd year     \_\_\_ 4th year

Have you taken USMLE Step III?     \_\_\_ Yes     \_\_\_ No     \_\_\_ Not Required

If yes, Date: \_\_\_\_\_ Numerical Score \_\_\_\_\_ Pass     Fail     (circle one)

If USMLE Step III is not required, please explain:

## P R O F E S S I O N A L L I A B I L I T Y

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?

\_\_\_ Yes     \_\_\_ No     If yes, please provide list and status on a separate sheet.

## D I S C I P L I N A R Y   A C T I O N S

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, placed on probation, not renewed, or voluntarily relinquished? If yes, please provide full explanation on a separate sheet.

- Medical license in any state ..... Yes \_\_\_ No \_\_\_
- Other professional registration/license ..... Yes \_\_\_ No \_\_\_
- DEA registration ..... Yes \_\_\_ No \_\_\_
- Academic appointment ..... Yes \_\_\_ No \_\_\_
- Membership on any hospital medical staff ..... Yes \_\_\_ No \_\_\_
- Clinical privileges ..... Yes \_\_\_ No \_\_\_
- Prerogative/rights on any medical staff ..... Yes \_\_\_ No \_\_\_
- Other institutional affiliation or status threat ..... Yes \_\_\_ No \_\_\_
- Professional society membership or fellowship/Board certification ..... Yes \_\_\_ No \_\_\_
- Professional office ..... Yes \_\_\_ No \_\_\_
- Any other type of professional sanction ..... Yes \_\_\_ No \_\_\_
- Professional liability insurance ..... Yes \_\_\_ No \_\_\_
- Have there been any felony criminal charges brought against you in the last five years ..... Yes \_\_\_ No \_\_\_
- Have you been convicted of any crimes ..... Yes \_\_\_ No \_\_\_

## H E A L T H   S T A T U S

(If any of these questions are answered in the affirmative, please provide full explanation on a separate sheet.)

- Do you presently have a physical or mental health condition, including Alcohol or drug dependence, that affects or is reasonably likely to affect Your ability to perform professional or medical duties appropriately? Yes \_\_\_ No \_\_\_
- Are you currently under care for a continuing health problem? Yes \_\_\_ No \_\_\_
- Have you at any time during the last five years been hospitalized or Received any other type of institutional care for a health problem? Yes \_\_\_ No \_\_\_

Comment:

## S I G N A T U R E

I hereby certify that to the best of my knowledge and belief, I have no physical or mental illness or mental defect which interferes with my professional appointment. All information submitted by me in this application is true and accurate to my best knowledge and belief. **(Please enclose a photo (optional)).**

Signature:

Date:

**Please submit this completed form to those institutions to which you are interested in applying. Photocopies are acceptable.**

**Please also send a copy of this form to the SSO Executive Office.**

Society of Surgical Oncology  
85 W. Algonquin Road, Suite 550  
Arlington Heights, IL 60005

# SSO MATCH PROGRAM APPLICATION

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## 2008 Surgical Oncology Fellowship Matching Program

### TO PARTICIPATE IN THE SSO MATCHING PROGRAM

- 1: Fill out the application form completely and legibly, and list, in rank order, your preference for surgical oncology fellowship training programs in which you would like to participate if you are selected. (Note: Most candidates arrange for personal interviews with their preferred programs. These are typically done prior to September.)
2. Enclose a check for the registration fee in the amount of \$50.00 made payable to: "The Society of Surgical Oncology"
3. Send this application form **and** check via overnight delivery or certified mail with return receipt requested, **TO ARRIVE NO LATER THAN SEPTEMBER 22, 2008**, to:  

**SOCIETY OF SURGICAL ONCOLOGY  
85 W. ALGONQUIN ROAD, SUITE 550  
ARLINGTON HEIGHTS, IL 60005**
4. The results of the Match are reviewed and verified by the Program Directors at the American College of Surgeons in October. You will be notified of the results of the Match on **OCTOBER 20, 2008 by email. Please include your correct email address on this form. Absolutely no information will be given out prior to this date.**
5. No Fax transmittals of Application will be accepted.
6. Once an Application has been received at SSO's executive office, no changes to the Application will be accepted.
7. It is the responsibility of the individual applicant to meet any and all requirements for fellowship enrollment at the matching institution. Failure to do so constitutes a basis for a training program to decline a match. SSO has no obligations in the event of an applicant's failure to meet program requirements.

**NOTE:** Applicants must send a completed "SSO General Surgical Oncology Fellowship Application" form **DIRECTLY to the individual institution(s)** which they are interested in attending **AS WELL AS a copy of the form to the SSO Executive Office.**

**Please remember the Deadline for receipt of  
Match Program Applications is September 22, 2008**

# SSO MATCH PROGRAM APPLICATION

## 2008 Surgical Oncology Fellowship Matching Program

Last Name:	First:	Middle:	
Home Mailing Address:	City:	State:	Zip:
Home Telephone Number:	Email Address:		
Office Mailing Address:	City:	State:	Zip:
Office Telephone Number:	Fax Number:		
Birthdate:	Social Security Number:		
Preferred Mailing Address: (Home or Office)			

**PARTICIPATING SITES**

**SITE CODE NUMBER**

- The University of Chicago .....01
- City of Hope National Medical Center .....02
- M. D. Anderson Cancer Center .....03
- Fox Chase Cancer Center .....04
- Memorial Sloan-Kettering Cancer Center .....05
- Ohio State University .....06
- Roswell Park Cancer Institute .....07
- John Wayne Cancer Institute .....08
- University of Miami School of Medicine .....09
- Boston University/Roger Williams Medical Center .....10
- H. Lee Moffitt Cancer & Research Institute .....11
- University of Pittsburgh – Hepatobiliary .....12A
- University of Pittsburgh – GI/Minimally Invasive .....12B
- University of Pittsburgh – Clinical Research .....12C
- University of Pittsburgh – Basic Research .....12D
- University of Toronto .....13
- University of Calgary .....14
- Virginia Commonwealth University .....15
- University of Louisville James Graham Brown Cancer Center .....16
- Dana Farber-Partners Surgical Oncology Fellowship .....17
- The Johns Hopkins Hospital & Sidney Kimmel Cancer Center .....18
- McGill University .....19

**PROGRAM PREFERENCE**

Please list your choice for a fellowship program in order of preference using the site code number.

1st Choice: _____	10th Choice: _____
2nd Choice: _____	11th Choice: _____
3rd Choice: _____	12th Choice: _____
4th Choice: _____	13th Choice: _____
5th Choice: _____	14th Choice: _____
6th Choice: _____	15th Choice: _____
7th Choice: _____	16th Choice: _____
8th Choice: _____	17th Choice: _____
9th Choice: _____	18th Choice: _____

**STATEMENT OF COMMITMENT**

Each applicant must read and sign the following commitment to be eligible to participate in the SSO Match Program.

"I agree to abide by the Match that is established through my participation in the Matching Program for Surgical Oncology Fellowships conducted by the Society of Surgical Oncology."

"I understand that I may not be matched, and, if matched, my enrollment will be contingent upon my meeting all requirements mandated by the matching institution."

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN DIRECTLY TO SSO EXECUTIVE OFFICE WITH YOUR \$50 PAYMENT BY SEPTEMBER 22, 2008.**