CHARLES H. NICHOLSON, M.D. FELLOWSHIP IN GENERAL SURGERY

Application for Clinical Tour for Surgical Residents

I hereby make Application for a Clinical Tour for Surgical Residents.

Name _____
(Last Name) (First Name) (Middle Name)

Residence _____
(Street number, City, State, Zip Code)

Date and Place of Birth _____

Are you a Citizen of the USA or Canada? _____

If a Naturalized Citizen state where and when you were naturalized _____

Date of Application _____ Signature of Applicant _____

We Vouch for _____

of _____ and recommend him/her to a Nicholson Clinical Tour.

Sponsored by _____

Approved by _____
(Chairman of Department)

Committee Record-Date Application Received _____

Action of Committee Recommended _____

Deferred _____

Not Recommended _____

Explanation Committee Action _____

_____

_____

_____
Secretary Signature

I SUBMIT THE FOLLOWING DATA CONCERNING MY EDUCATION AND SURGICAL TRAINING.

1. Premedical Education

_____ From _____ To _____ Degree _____
(University or College)

_____ From _____ To _____ Degree _____

_____ From _____ To _____ Degree _____

2. Medical Education

_____ From _____ To _____ Degree _____

_____ From _____ To _____ Degree _____

3. Internship

_____ From _____ To _____
(Hospital)

_____ From _____ To _____

4. Training following Internship:

a. Residency or Fellowship:

_____ From _____ To _____
(Hospital)

_____ From _____ To _____

b. When will you complete your Surgical Training? _____

c. If approved, at what time will you take the Tour? _____

5. Other Professional Experience such as Basic Science, Private Practice, Investigative Work and any Special Awards.

_____

_____

_____

_____

6. Please Attach Bibliography.