

**THE METHODIST HOSPITAL  
GRADUATE MEDICAL EDUCATION TRAINING PROGRAMS  
APPLICATION FOR NON-MATCH OR TRANSFER APPLICANTS**

Please attach  
a small  
passport style  
photo here

**I. IDENTIFYING INFORMATION**

Date of Application:

PROGRAM APPLYING FOR: **METHODIST SPORTS MEDICINE FELLOWSHIP**

Last Name:	First Name:	Middle Name:	Suffix:	Other Name(s) used in training:
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Gender:	Ethnic origin: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other
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Date of Birth:	Place of Birth:	Social Security Number:
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Citizenship:	If not a citizen or permanent resident, type of visa held:
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Visa expiration date:	Date of entry into the United States:
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Languages spoken other than English:

**II. ADDRESS**

Mailing Address:	Home Address:
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City, State, Zip	City, State, Zip
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Home Phone:	Cell Phone:
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Contact Phone:	Email Address:
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**III. LICENSURE (IF AVAILABLE)**

Type:	Number:	Expiration Date:
Texas State License:		
Texas Physician – in – training permit:		
DEA:		
DPS:		
Other State License:		

**IV. BOARD CERTIFICATIONS**

TYPE	BOARD NAME	CERTIFICATION DATE	EXPIRATION DATE
<input type="checkbox"/> NEW <input type="checkbox"/> RECERT			

V. EDUCATION		
MEDICAL SCHOOL (last to first in chronological order)		
1. Name of Institution:		Dates Attended: From: (mm/yy) <span style="float: right;">To: (mm/yy)</span>
City, State		Date Degree Awarded:  Degree:  Major:
2. Name of Institution:		Dates Attended: From: (mm/yy) <span style="float: right;">To: (mm/yy)</span>
City, State		Date Degree Awarded:  Degree:  Major:
3. Name of Institution:		Dates Attended: From: (mm/yy) <span style="float: right;">To: (mm/yy)</span>
City, State		Date Degree Awarded:  Degree:  Major:
POST GRADUATE TRAINING		
List in chronological order <u>every postgraduate training program</u> you have been associated with. Attach additional sheets if necessary. Reference this section number and title.		
1. <b><u>Internship:</u></b>		Dates Attended: From: (mm/yy) <span style="float: right;">To: (mm/yy)</span>
Program Name:		Type: Internship, if separate from residency Residency, Fellowship
Mailing address:		Program Director:
City:	State & Zip	Phone:
Country:		Fax:






XII. Applicant Attestation

By my signature, I declare that all information provided by me or on my behalf, within this application or in conjunction with this application, has been submitted truthfully and accurately.

I understand that it is my sole responsibility to immediately submit an update of this questionnaire to The Methodist Hospital GME Office in the event that any answer(s) to any of these questions become inaccurate or incomplete while my application is in process. I also understand that failure to do so may constitute cause to deny entry into an THE Methodist Hospital program.

I hereby authorize the release to The Methodist Hospital all records and documents bearing on my professional competence, character, training, ethical qualifications and any other material necessary to render an evaluation of my appointment to the House Staff The Methodist Hospital.

I further agree to be bound by the terms thereof in all matters relating to the consideration of my application, and I further agree to abide by such hospital and staff policies, rules and regulations as may be from time to time enacted.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Applicant's Printed Name:** \_\_\_\_\_

**I authorize the release of this information to all persons associated with The Methodist Hospital Graduate Medical Education and its training programs, as necessary, for processing of this application.**

**I certify that the above information is true and correct.**

Signature \_\_\_\_\_ Date (M/D/Y) \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE COMPLETE ALL INFORMATION ON EACH PAGE**  
**INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED**

## Dear Applicant

Thank you for your inquiry regarding our Fellowship Program in Orthopedic Surgery.

Your application will be considered for interview only if all of the following documents have been received:

- Completed Methodist Application Form
- Current Curriculum Vitae or resume
- Personal Statement, not to exceed one page, single-spaced minimum of 12 point type face
- Four letters of recommendation, of which one must be from the Dean of Students at your Medical College
- Notarized copy of your medical school diploma
- Notarized copy of your medical school transcript
- Copy of Board Scores (USMLE Step 1 & Step 2)
- Copy of state license, PIT (if available)

All documents must contain the statement “notarized as a true copy of an original document” on the front of each page. All documents must be 8 ½ inches by 11 inches.

Interviews are by invitation only and only applicants with the completed applications will be considered.

Applications will be accepted until Dec 1 and interviews will take place in January 2007.

Letters may be addressed to

David M. Lintner, MD., Director, Methodist Sports Medicine Fellowship. (address below)

Again, thank you for your interest in our training program.

Adriana Perez  
Fellowship Coordinator  
Methodist Center for Orthopaedic Surgery  
**6560 Fannin, Suite 400**  
**Houston, TX 77030**  
713-441-3560  
713-790-2054 (fax)  
[adperez@tmh.tmc.edu](mailto:adperez@tmh.tmc.edu)  
[www.drhintner.com](http://www.drhintner.com)