

APPLICATION FOR PRINCE OF WALES HOSPITAL FOOT AND ANKLE FELLOWSHIP

IT IS IMPORTANT TO PROVIDE DETAILED ANSWERS AS THIS INFORMATION WILL BE USED TO ASSIST WITH IMMIGRATION AND MEDICAL BOARD REGISTRATIONS

SURNAME

GIVEN NAMES

DATE OF BIRTH

CITIZENSHIP

MARITAL STATUS

HOME ADDRESS

CONTACT NUMBERS

AH:

MB:

EMAIL

LANGUAGES SPOKEN

PRESENT POSITION TITLE

**NAME OF UNIVERSITY /
HOSPITAL**

HEAD OF DEPARTMENT

BUSINESS ADDRESS

**BUSINESS CONTACT
NUMBERS**

PH

FX

UNDERGRADUATE MEDICAL EDUCATION

**TITLE OF UNDERGRADUATE
MEDICAL DEGREE**

NAME OF UNIVERSITY

DEGREE DURATION

DATE OF COMPLETION

If there is insufficient space available please attach additional information

POSTGRADUATE MEDICAL EDUCATION

ORTHOPAEDIC SURGERY

WHERE

DATE OF COMPLETION

TITLE RECEIVED

OTHER

WHERE

DATE OF COMPLETION

TITLE RECEIVED

If there is insufficient space available please attach additional information

POSTGRADUATE SPECIALIST TRAINING

1 WHERE

**DATE OF
COMPLETION**

TITLE RECEIVED

ACTIVITIES

2 WHERE

**DATE OF
COMPLETION**

TITLE RECEIVED

ACTIVITIES

If there is insufficient space available please attach additional information

SPECIALIST EMPLOYMENT (IF APPLICABLE)

1 POSITION TITLE

WHERE

DATES

ACTIVITIES

If there is insufficient space available please attach additional information

DO YOU HAVE ANOTHER DEFINITE APPOINTMENT?

YES

NO

WHERE

POSITION

WHEN

**PLEASE INDICATE THE MOST CONVENIENT DATE(S)
FOR YOUR FELLOWSHIP**

**IF YOU WERE ACCEPTED INTO THE PROGRAM WOULD
FAMILY MEMBERS ACCOMPANY YOU?**

YES

NO

**IF SO, PLEASE PROVIDE THEIR
FULL NAMES AND DATE OF
BIRTH AS INDICATED ON
THEIR PASSPORT**

1

DOB

2

DOB

3

DOB

4

DOB

LIST THREE PROFESSIONAL REFEREES, INCLUDING CONTACT DETAILS

1

2

3

