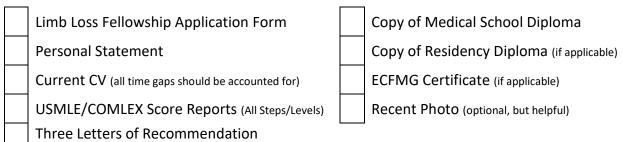
Amputee Rehabilitation Fellowship Application 2024-2025 Spaulding Rehabilitation Hospital

Congratulations on deciding to pursue specialized training in Amputee Rehabilitation! This document is intended to guide you through the application process. Applicants are expected to have completed an ACGME Physical Medicine & Rehabilitation accredited residency. The application below, as well as all supporting documents, should be emailed to Megan Gentile at mgentile6@mgb.org. There may be supplemental information requested by the program, but it should not duplicate the information you supply below, and could be requested at a later time. The Limb Loss Fellowship at Spaulding Rehabilitation Hospital is a non-ACGME accredited fellowship. We do not go through the NRMP Match.

Limb Loss Fellowship Application Important Dates					
Sept 1-October 1, 2024	Suggested submission window of this application & supporting material.*				
Nov & Dec 2024	Virtual interview or visit with program, if possible and desired				
January 11, 2025	Limb Loss Fellowship offer to go out				
August 1, 2025	First Day of Fellowship				

*It is highly recommended to submit on or before October 1st to give adequate time for the program to review your application and arrange for an interview. The program may accept applications on a case-by-case basis after this date.

Application Checklist



(Letters should be sent directly to program rather than in this packet, if requested by letter writer or fellowship program)

Amputee Rehabilitation Fellowship Application Form

Name (Last, First	t, Middle):					Date o	f Birth:	
Permanen	t Address:						eferred onouns:	
Mailing Address (if different):							
E-mail Address:			F	hone #:			Citizenship:	
NPI #:			Medical (if	License: applicable)	State: -		License #	
International Grads:	ECFMG Cert	ificate #:			Cer	tificate Date:		
lf you are not a U.S. Citizen:	Can you curr Current Visa	rently work in the Type:	e U.S.? Ye			Current Vi e for Fellowsh	sa Expiration Date:	
Education		Institution	& City/State		Deg	ree	Dates	
Undergrad School:								
Graduate School:								
Medical School:								
Internship:								
Residency:								
Residency:								
Fellowship:								
Other:								
Score H	Step 1	Step 2 CK	Step 2 CS	Step 3	ИЕХ	Level 1	Level 2	Level 3

Date S Image:	56616	Ē					5			
	Date						NO.			
	Retook exam?		Y / N	Y / N	Y / N	Y / N	C	Y / N	Y / N	Y / N

Reference Name	Institution/Position	Phone	E-mail
1.			
2.			
3.			

The information contained in this application (and accompanying documents) is accurate and true to the best of my knowledge.

Signature: _____ Date: _____