Hurley Trauma (and Advanced Trauma) Fellowship Application – Instructions

To apply to a Trauma Fellowship at Hurley Medical Center in Flint, Michigan, please complete the Hurley Trauma (and Advanced Trauma) Fellowship Application (attached), then follow the instructions below.

Send the following to the attention of Program Director Michael McCann DO at Hurley Medical Center, 7B Trauma Services, One Hurley Plaza, Flint MI 48503:

- Completed Hurley Trauma (and Advanced Trauma) Fellowship Application
- Passport-size photo (2x2 inches)
- Letter of interest
- Curriculum vitae
- 3 letters of recommendation (Per application instructions – ask that your referrals be sent directly to Hurley.)

Questions? Contact us at:

Hurley Medical Center
One Hurley Plaza
7B Trauma Services Dept
Flint, MI 48503-5993
PTippet1@hurleymc.com
810-262-9355

Visit us at:

- Hurley Graduate Medical Education Blog: [http://education.hurleymc.com/blogs](http://education.hurleymc.com/blogs)
- Hurley Graduate Medical Education Facebook Page: [https://www.facebook.com/HurleyGME](https://www.facebook.com/HurleyGME)
Trauma (and Advanced Trauma) Fellowship Application

This application is for (Select one):

- Trauma Surgery Fellowship
- Advanced Trauma Surgery (Research) Fellowship

Full Name: ____________________________________________
Last First Middle

Present Address: _________________________________________
Street Address ____________________________________________________________________________
Apartment/Unit #
City State ZIP Code

Permanent Address: _________________________________________
Street Address ____________________________________________________________________________
Apartment/Unit #
City State ZIP Code

Phone: ( ) ___________________________ Cell Phone: ( ) ___________________________

E-mail Address: _________________________________________

Social Security No: __________ - _______ - ___________ Date of Birth: ________ / ______ / __________

Are you a citizen of the United States?   ☐ Yes   ☐ No
If no, visa status:

When do you wish to begin your training?   Month: __________________ Year:

Education
List all undergraduate, graduate and medical school education in chronological order.

Institution Location/State Date of Attendance Degree & Date
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________

Medical Training
List all previous postgraduate training/experience, in chronological order.

Institution Location/State Date of Attendance Degree & Date
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________
__________________________________________ ____________________________________________
Other Experience
If your training has not been continuous since graduation from medical school, please provide an explanation.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How did you hear about us?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Examinations
Please submit the following documents:

- USMLE Step 1
- USMLE Step 2 (Clinical Knowledge)
- USMLE Step 2 (Clinical Skills)
- USMLE Step 3
- Personal Statement
- Medical School Graduation Certificate
- ECFMG Certificate, If Applicable

Licensing Information
Do you have a current medical license? □ Yes □ No State(s) ____________________________________________
Do you have a current controlled substance license? □ Yes □ No # _______________________________________

References
Please contact the individuals listed below and ask them to forward a reference directly to the Graduate Medical Education Office.

Name/Title
Address

Dean
1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________

Disclaimer and Signature

□ I certify that my answers are true and complete to the best of my knowledge.
□ If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: __________________________________________________________ Date: __________________________

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