**Application for International Training Program on Thoracic Surgery**

**Dear Applicant,**

Thank you for your interest in applying for international training program on thoracic surgery at Shanghai Pulmonary Hospital. This program offers half-year and one-year for thoracic surgeons and medical students who are interested in thoracic surgery and related clinical and fundamental research. Please fill out this application form carefully and email all the required documents to our department. Please note that only completed application will be forwarded to our Review Committee.

**Required documents:**

 □ Completed Application Form

□ Current Curriculum Vitae (including publications, awards, honors, memberships, research experience)

□ Certificate of Medical License (with English translation if not in English)

□ Certificate of Medical Degree (with English translation if not in English)

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| Applicant Name |
| *Last name* | *First name*  | *Middle name* |
|  |  |  |
| Preferred Category |
| □ Half-year | □ One-year |
| Preferred Speciality (Please check one) |
| □ Minimally invasive pulmonary surgery□ Lung transplantation□ Mediastinal surgery□ Tracheobronchial surgery□ Chest wall surgery |
| Preferred Start Date:  |
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Please attach a recent passport-sized photo here

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| Part1: Personal Details  |
| Gender  | Date of Birth  | Nationality  |
| E-mail Address:  |
| Home Address: |
| *Street* | *City*  | *State* | *ZIP/Postal code*  |
|  |  |  |  |
| Telephone |
| Mobile:  | Home：  |
| Current Place of Work:  |
| Current Professional Status: □Medical student □Resident □Fellow □ Attending/Specialist □ Other\_\_\_\_\_\_\_\_\_\_\_ |

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| Part 2. Education  |
|  | Name of University, City and Country | Years of Attendance  |
| From | To |
| Undergraduate Degree  |  |  |  |
| Medical degree  |  |  |  |
| Graduate degree (if applicable) |  |  |  |
| Residency  |  |  |  |

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| Part 3. Other experiencePlease list your other training, work or research experience in chronological order |
| *From*  | *To*  |  |
|  |  |  |
| *From*  | *To*  |  |
|  |  |  |
| *From*  | *To*  |  |
|  |  |  |

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| Part 4. Medical Licensure Please provide detailed information of the license which you hold for medical practice. If an application is pending in state, please type “pending”. |
| *Medical License Number*  | *Date issued*  | *Expiration Date* | *State*  |
|  |  |  |  |
| How many years of thoracic surgery experience?  |  |
| How many cases of thoracic surgery you have done? |  |
| Have you ever had your license suspended or revoked? | □Yes □No |
| Have you ever been disciplined by any state or local medical board? | □Yes □No |

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| Part 5. Applicant’s Goals and Objectives |
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| Part 6. Signature I hereby certify that all the information provided above is complete, truthful and accurate  |
| *Signature*  | *Date* |
|  |  |

**You may complete the application and submit all the requested documents to our department by email:** Thoracic\_SHPH@126.com