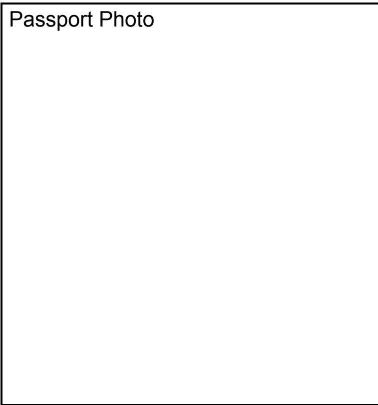

MUSCULOSKELETAL IMAGING OBSERVERSHIP APPLICATION

Affiliated With
New York Presbyterian Hospital
AND
Weill Medical College of Cornell University
535 East 70TH Street
New York, New York 10021

NOTE: Please type or print clearly all entries

DATE OF APPLICATION __________

Requested Focus/Foci (check all that apply)

[ ] General Musculoskeletal Imaging
[ ] Dedicated Ultrasound
[ ] Dedicated Interventional
[ ] Dedicated Musculoskeletal CT
[ ] Dedicated MRI
[ ] *One on One* Instruction
[ ] Other_________________

NAME: ____ ___/___/___
Last **First** **Middle** **D.O.B.: month** **day** **year**

PRESENT ADDRESS: ____
Street **City** **State** **Zip Code**

PHONE: HOME:______________________________ **WORK**: ______________________________
(include city and country code if applicable)

E-MAIL: ______________________________ **PAGER**: ______________________________

PERMANENT ADDRESS: ____
Street **City** **State** **Zip Code**

CITIZENSHIP: ______________________________ **PLACE OF BIRTH**: ______________________________
(City / State / Country)

Emergency Contact (name) ____

ADDRESS:

____
City **State** **Zip Code**

PHONE: DAY______________________________ **EVENING** ______________________________

Fee Schedule (effective 7/1/2007)

$500 per ½ day

$1000 per day

$4,500 for one week (10% discount applied)

One on One: If you are interested in scheduling individual, *one on one*, instruction with a particular radiologist on our faculty, or with a technical staff member, arrangements are dependent on availability and a different fee structure applies. If you are interested in a *one on one* visit, a representative from the Education Division will contact you with details.

About the Fee

Fees support the educational and research academic mission of the Department. Thank you.

Curriculum Vitae

Please include your C.V. with this application.

Survey

Please complete the attached survey (page 3).

Length and Date(s) of Visit

Proposed Length of Stay (circle one): ½ 1 1½ 2 2½ 3 3½ 4 4½ 5 day(s)

- **Dates: 1st Choice ______________ 2nd Choice ______________ 3rd Choice_______________**

I certify that the foregoing information is accurate to the best of my knowledge.

_______________________________________ SIGNATURE OF APPLICANT

_____________________ DATE

The application must be completed in its entirety before it can be processed.

Observerships are subject to the discretion of the Department of Radiology and Imaging.

APPLICATION, C.V., AND ALL RELATED COMMUNICATIONS SHOULD BE ADDRESSED TO:

Department of Radiology & Imaging
Education Division - Observerships
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
(212) 606-1923
FAX: (212) 774-7830
wallacet@hss.edu

Please take a few minutes to complete our survey.

HOW DID YOU HEAR ABOUT THE OBSERVERSHIP PROGRAM?

- HSS WEBSITE
- HSS PHYSICIAN / STAFF REFERRAL
  NAME ____
  HOW DO YOU KNOW THIS HSS EMPLOYEE ____________________
- EXTERNAL REFERRAL
  NAME ____
  HOW DO YOU KNOW THIS PERSON ___________________________
- COLLEAGUE
  NAME ____
  HOW DO YOU KNOW THIS COLLEAGUE _________________________
- PREVIOUS VISITOR
  NAME ____
  HOW DO YOU KNOW THIS VISITOR _______________________________
  PHYSICIAN/SERVICE THE VISITOR WAS UNDER ____________________

IF YOU ARE A PRACTICING, LICENSED PHYSICIAN:

- FIELD/SPECIALTY ____

  HOW LONG HAVE YOU BEEN IN PRACTICE _________________________________

  WHAT IS THE NATURE OF YOUR PRACTICE?

  - HOSPITAL
  - PRIVATE PRACTICE
  - BOTH

IF YOU ARE NOT A LICENSED PHYSICIAN:

- WHAT IS YOUR CURRENT STANDING IN HEALTHCARE?

  MEDICAL STUDENT RESIDENT FELLOW

  ALLIED HEALTHCARE PROFESSIONAL (PLEASE SPECIFY) __________________

PURPOSE OF VISIT:

- ENHANCE YOUR PROFESSIONAL GOALS
- INITIAL EXPERIENCE IN CLINICAL SETTING
- NETWORKING
- EXPOSURE TO NEW PROCEDURES