PHOTO

PARIS SHOULDER UNIT

22 rue Georges Bizet 75116 PARIS

Phone : +33 (0)1 84 130 453

www.parisshoulderunit.com

APPLICATION FORM – SHOULDER FELLOWSHIP

Chairman: Ph. VALENTI, MD

PERSONAL INFORMATION

Last Name: ……

First name: ……

Birth date: _ _ /_ _ /_ _ _ _

Marital situation: ……

Children: ☐ Yes ☐ No If yes, number: _ _ _ _

Address: ……

City: ……

Zip Code: ……

Country: ……

Nationality: ……

Languages spoken:

- Mother tongue: ……
- Other: ……
  ……

WORK INFORMATION

Work Address: ……

……

Work Phone: ……

Email: ……

Fellowship period required *(Training periods begin on May and November 1st for 6 or 12 months. Specify the year):*

- 1st choice: *from*……*to*……
- 2nd choice: *from*……*to*……
- 3rd choice: *from*……*to*……

DOCUMENT ATTACHED TO THE APPLICATION FORM:

- 2 pictures (*one for the application and the other for the institute's web site*)
- CV (*specify the Institution, city/country, dates of medical studies, date of medecine diploma, date of speciality diploma*)
- Cover letter
- References
- Recent publications

Please fill and send this application form with all the documents to

Dr Philippe VALENTI

philippe.valenti@parisshoulderunit.com

and to

Ms Imen NID TAHAR

imen.arc@parisshoulderunit.com