



PARIS
HAND AND
SHOULDER UNIT

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APPLICATION FORM – SHOULDER FELLOWSHIP

Chairman: Ph. VALENTI, MD

PERSONAL INFORMATION

Last Name:

First name:

Birth date: __/__/----

Marital status:

Children: Yes (number: __) No

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 medicine 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