SVS
Society for Vascular Surgery

INTERNATIONAL SCHOLARS PROGRAM

Application must be completed in English. Fields with an asterisk* are required.

*FIRST NAME | *MIDDLE NAME

*LAST NAME

*ADDRESS 1

*ADDRESS 2

*CITY | STATE/ PROVINCE

*POSTAL CODE | *COUNTRY

*PHONE | FAX

*EMAIL

PLACE OF BIRTH | *CITIZENSHIP

*DATE OF BIRTH | *GENDER ☐ MALE ☐ FEMALE

Have you previously applied for the international scholars program? ☐ YES ☐ NO

LICENSURE

Please indicate information about your license to practice surgery. Enter at least one.

STATE, PROVINCE, OR COUNTRY

LICENSE TYPE ☐ FULL ☐ RESTRICTED

LICENSE NUMBER | DATE ORGINALLY ISSUED ☐☐/☐☐☐☐

STATE, PROVINCE, OR COUNTRY

LICENSE TYPE ☐ FULL ☐ RESTRICTED

LICENSE NUMBER | DATE ORGINALLY ISSUED ☐☐/☐☐☐☐

AREA OF PRACTICE

Indicate your specialties along with the amount of time you dedicate to each area listed. Enter at least one.

SPECIALTY | PERCENTAGE OF TIME IN SPECIALTY ☐ %

SPECIALTY | PERCENTAGE OF TIME IN SPECIALTY ☐ %

ACADEMIC APPOINTMENTS

Where do you teach and hold an academic appointment? Enter at least one.

NAME OF MEDICAL SCHOOL

FACULTY POSITION AND DEPARTMENT

BEGIN DATE (MM/YYYY) ☐☐/☐☐☐☐ | END DATE (MM/YYYY) ☐☐/☐☐☐☐ | OR CURRENT ☐

NAME OF MEDICAL SCHOOL

FACULTY POSITION AND DEPARTMENT

BEGIN DATE (MM/YYYY) ☐☐/☐☐☐☐ | END DATE (MM/YYYY) ☐☐/☐☐☐☐ | OR CURRENT ☐

CERTIFICATION BY SPECIALTY BOARDS

Enter at least one or indicate not applicable.

NAME OF SPECIALTY BOARD

DATE OF CERTIFICATION ☐☐/☐☐☐☐ CERTIFICATION NUMBER

NAME OF SPECIALTY BOARD

DATE OF CERTIFICATION ☐☐/☐☐☐☐ CERTIFICATION NUMBER

OTHER COLLEGE FELLOWSHIP OR CERTIFICATION (e.g., Royal College of Surgeons)

NAME

NAME

PRE-MEDICAL EDUCATION

Enter at least one.

NAME OF UNIVERSITY LOCATION

DEGREE(S)

GRADUATION DATE ☐☐/☐☐☐☐ BEGIN DATE (MM/YYYY) ☐☐/☐☐☐☐ END DATE (MM/YYYY) ☐☐/☐☐☐☐

NAME OF UNIVERSITY LOCATION

DEGREE(S)

GRADUATION DATE ☐☐/☐☐☐☐ BEGIN DATE (MM/YYYY) ☐☐/☐☐☐☐ END DATE (MM/YYYY) ☐☐/☐☐☐☐

MEDICAL SCHOOL

*From what medical school did you graduate?

NAME OF MEDICAL SCHOOL

LOCATION

DEGREE

GRADUATION DATE ☐☐/☐☐☐☐ BEGIN DATE (MM/YYYY) ☐☐/☐☐☐☐ END DATE (MM/YYYY) ☐☐/☐☐☐☐

LETTERS OF RECOMMENDATION

Applicants are required to submit letters of recommendation from no more than three of their colleagues. One letter of recommendation must be from the chair of the department in which they hold an academic appointment or a member of the Society for Vascular Surgery who resides in the applicant's country. The Chair's or the member's letter must include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant.

QUESTIONS?

Please contact **Justin Cogswell at 312-334-2306 or by email at membership@vascularsociety.org** if you have questions.