



EMERGENCY ULTRASOUND ATTENDING MINI-FELLOWSHIP



APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Week Request	1.	2.	
Are you a citizen of the United States?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>
EMPLOYMENT			
Institution	Title		
Address			
REFERENCES			
<i>Please list Department Chair</i>			
Full Name	Institution		
E-mail	Phone ()		
DISCLAIMER AND SIGNATURES			
I certify that my answers are true and complete to the best of my knowledge.			
I understand that false or misleading information in my application may result in release from the rotation.			
Applicant Signature		Date	
I certify that _____ fulfills all of the following:			
(Applicant)			
1. Is covered by his/her own institutional malpractice insurance policy			
2. Has cleared pre-employment and ongoing employee health requirements			
Department Chair Signature		Date	

Please return to: Ericka Salas, Ultrasound Division Administrative Assistant, Department of Emergency Medicine
Roosevelt Hospital, Room GE-01, 1000 Tenth Avenue, New York, NY 10019
Phone: (212) 523-8158, Fax: (212) 523-8000