NEW YORK GYNECOLOGICAL SOCIETY
APPLICATION FOR FELLOWSHIP

Name

Address Office **Tel.**

Home **Tel.**

Email Address

Age

College **Degree** **Date**

Medical School **Degree** **Date**

Internship—(Hospital, Dates and Type of Service)

Residency—(Hospital, Dates and Type of Service)

Hospital Appointments—(Past and Present, Date in Full)

Teaching Positions

Member of County Medical Society **From** **To**

Member of Academy of Medicine **From** **To**

Diplomate of Specialty Board

Date of Certification

Other Medical Societies (Including F.A.C.S., F.A.C.O.G., etc.)

Private Practice Limited to Specialty
Military Experience
No. end Date of New York Medical License
Were Any of Your Licenses Suspended or Revoked? If yes, attach explanation

Record of Published Writings or Research (List Dates and Where Published)

Recommended By:

1. **Name**
   Address

2. **Name**
   Address

Date **Signature of Applicant**_____

For Secretary's Use Only:

Date Application Received:
Action of Membership Committee
Action of Council **Elected**

****Two Letters of Recommendation Are Essential****