

Department of Surgery

**PA Surgical Residency**

Program Application

**Date of Application:**       **Date you wish program to begin:**

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| **Personal Data** |
| Name: Last      | First Middle      |
| Mailing Address: Number and Street      | City, State & Zip Code       |
| Home Phone      | Daytime Phone      |
| Email Address      | Cell Phone       |
| Permanent Address (if different)       | Permanent Phone (if different)      |
| Date of Birth      | [ ]  Male | [ ]  Female |
| **Education** |
| Institution: Include full name, location and any honors | Dates Attended | Degree Conferred |
| FromMo/Yr | ToMo/Yr | Type | DateMo/Yr |
| Undergraduate      |       |       |       |       |
| Physician Assistant Program      |       |       |       |       |
| Graduate work (doctoral or master)      |       |       |       |       |
| Graduate work (doctoral or master)      |       |       |       |       |
| **Other Clinical/Work Experience:** List chronologically your activities, if any, from the time of graduation from PA school *to the present*.  |
| Type      | Location      | Dates      |
| Type      | Location      | Dates      |
| Type      | Location      | Dates      |
| **Curriculum Vitae**  |
| Please attach a current curriculum vitae with your fellowship application. |
| **Photograph**  |
| Please attach passport size photograph with your application. |
| **Licenses or Certification** |
| Do you hold a current PA certification? [ ]  Yes [ ]  No If so, list expiration date here      Any other clinical licenses or certifications: List here       |
| **Letters of Recommendation Requested** At least three (3) letters of recommendation from faculty members/preceptors from your training program. One of these letters must be from the current or previous department head or training program director. List below the names and mailing addresses of your letter writers. Please ask your letter writers to send their letter to the address on last page. |
| 1.        |
| 2.        |
| 3.        |
| Have you ever been convicted of a felony? [ ]  Yes [ ]  No If yes, please explain on a separate sheet of paper. |  |
| Please sign your name and date below if you agree with the following statement:*The information I have given in this application is current and complete to the best of my knowledge.*Signature (your name here): Date:        |
| **Enclose with this Application*** CV
* Personal Statement
* PA School Program diploma (if applicable)
* PA School Program transcripts (if applicable)
* Copy of PA Certification (if applicable)
* Letter of good standing from Program Director if currently enrolled in a PA program
 |
| For office use only:  [ ]  Curriculum Vitae [ ]  Letters of recommendation [ ]  Photograph [ ]  Personal Statement [ ]  Other |
|  |
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|  |
|  |

**RETURN COMPLETED APPLICATION WITH ENCLOSURES TO:**

George Arnaoutakis, M.D.

Assistant Professor of Surgery

Department of Surgery

University of Florida College of Medicine – Division of Thoracic and Cardiovascular Surgery

PO Box 100287

Gainesville, FL 32610-0287

Email: George.arnaoutakis@surgery.ufl.edu

Fax: (352) 273-5593

For questions - Phone: (352) 265-0916