



12 rue de Chaillot 75116 PARIS

Phone : +33 (0)1 84 130 456

[www.parisshoulderunit.com](http://www.parisshoulderunit.com)

## APPLICATION FORM – SHOULDER FELLOWSHIP

Chairman: Ph. VALENTI, MD

### PERSONAL INFORMATION

Last Name: .....

First name: .....

Birth date: \_\_/\_\_/----

Marital situation: .....

Children:  Yes  No If yes, number: \_\_\_\_

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 1<sup>st</sup> for 6 or 12 months. Specify the year*):

- 1<sup>st</sup> choice: *from*.....*to*.....
- 2<sup>nd</sup> choice: *from*.....*to*.....
- 3<sup>rd</sup> 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](mailto:philippe.valenti@parisshoulderunit.com)

and to

Ms Imen NID TAHAR

[imen.arc@parisshoulderunit.com](mailto:imen.arc@parisshoulderunit.com)