The American Board of Plastic Surgery, Inc.®

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RESIDENT REGISTRATION AND EVALUATION OF TRAINING FORM

Please type or print clearly all applicable information

1. NAME	LAST NAME / FIRST NAME / MIDDLE NAME SUFFIX / MAIDEN NAME
2. COMPLETE ADDRESS ❑ **HOME** ❑ **OFFICE**	CITY / STATE / ZIP CODE
3. TELEPHONE NUMBERS	**HOME** – – **OFFICE** – – **CELL** – –
4. EMAIL ADDRESS	**5. SOCIAL SECURITY NUMBER**
6. DATE OF BIRTH	MONTH / DAY / YEAR **7. PLACE OF BIRTH** CITY AND STATE OR PROVINCE OR COUNTRY
8. NAME OF MEDICAL SCHOOL	INCLUDE CITY AND STATE OR PROVINCE OR COUNTRY **(SUBMIT PHOTOCOPY OF YOUR DIPLOMA)**
9. TYPE OF MEDICAL DEGREE	MD YEAR GRANTED DO YEAR GRANTED MBBS or MBChB YEAR GRANTED
10. NAME OF DENTAL SCHOOL	INCLUDE CITY AND STATE OR PROVINCE OR COUNTRY **(SUBMIT PHOTOCOPY OF YOUR DIPLOMA)**
11. TYPE OF DENTAL DEGREE	DDS YEAR GRANTED DMD YEAR GRANTED

12. PREREQUISITE RESIDENCY TRAINING Please list each PGY Level completed and anticipated for your full training years individually and in chronological order. Integrated Plastic Surgery Residents list all training under number 13.

NAME OF PROGRAM	CITY AND STATE OR PROVINCE	FROM DATES MONTH/DAY/YEAR	TO DATES MONTH/DAY/YEAR	YEAR LEVEL	NO. OF MONTHS	SPECIALTY
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NAME OF PROGRAM DIRECTOR

13. RESIDENCY TRAINING IN PLASTIC SURGERY ONLY. Please list each PSY Level completed and anticipated individually and in chronological order.

NAME OF PROGRAM	CITY AND STATE OR PROVINCE	FROM DATES MONTH/DAY/YEAR	TO DATES MONTH/DAY/YEAR	YEAR LEVEL	NO. OF MONTHS
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NAME OF PROGRAM DIRECTOR

14. FELLOWSHIP(S) FOLLOWING PLASTIC SURGERY RESIDENCY.

NAME OF PROGRAM,CITY AND STATE OR COUNTRY	TYPE	FROM DATES MONTH/DAY/YEAR	TO DATES MONTH/DAY/YEAR	NO. OF MONTHS
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15. List your entire prerequisite training sequence in chronological order to include month by month rotations. Only list training completed in the United States and/or Canada. This training must include the date you began until the date you completed or expect to complete the program.

Include training in general surgery as well as other specialties and full time Research and Fellowships. See first two lines for example.

Required clinical experience appropriate to plastic surgery education must be provided in the following content areas:

1. Abdominal surgery
2. Oncologic/Breast Surgery
3. Pediatric Surgery
4. Surgical Critical Care
5. Surgical oncology (non-breast)
6. Transplant
7. Trauma management
8. Vascular surgery

Residents in **Integrated Plastic Surgery Programs** must list month by month rotations as anticipated or scheduled from PSY-I - PSY-III.

FROM DATES MONTH DAY YEAR	TO DATES MONTH DAY YEAR	NO. OF MONTHS	SPECIALTY	NAME OF PROGRAM, CITY AND STATE OR PROVINCE
5/1/15	*6/30/15*	*2*	*VASCULAR*	*CITY GENERAL HOSPITAL, PHILADELPHIA, PA*
7/1/15	*9/30/15*	*3*	*TRAUMA*	*CITY GENERAL HOSPITAL, PHILADELPHIA, PA*
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FROM DATES MONTH DAY YEAR	TO DATES MONTH DAY YEAR	NO. OF MONTHS	SPECIALTY	NAME OF PROGRAM, CITY AND STATE OR PROVINCE
5/1/15	6/30/15	2	VASCULAR	CITY GENERAL HOSPITAL, PHILADELPHIA, PA
7/1/15	9/30/15	3	TRAUMA	CITY GENERAL HOSPITAL, PHILADELPHIA, PA
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16. ARE YOU ADMISSIBLE TO THE EXAMINATION PROCESS OR CERTIFIED BY ONE OF THE FOLLOWING BOARDS? IF SO, CHECK WHICH ONE AND INCLUDE DOCUMENTATION: (Approval Letter, Result Letter or Certificate)

- ❏ American Board of Neurological Surgery
- ❏ American Board of Oral and Maxillofacial Surgery
- ❏ American Board of Orthopaedic Surgery
- ❏ American Board of Otolaryngology
- ❏ American Board of Surgery
- ❏ American Board of Urology

17.

RESIDENT SIGNATURE

MONTH / DAY / YEAR

Submit the following to the Board Office:

- Completed 5 page Form
- Processing Fee
- Medical School Diploma
- Dental School Diploma (if applicable)
- Board Approval Letter, Result Letter or Certificate (if applicable)
- CaRMS Letter (if applicable)

Failure to correctly submit required materials in their entirety may result in a Missing Items Fee.