

The American Board of Plastic Surgery, Inc.®

Seven Penn Center • Suite 400 • 1635 Market Street • Philadelphia, PA 19103-2204
 Phone: 215-587-9322 • E-mail: info@abplasticsurgery.org • Internet: http://www.abplasticsurgery.org



RESIDENT REGISTRATION AND EVALUATION OF TRAINING FORM

Please type or print clearly all applicable information

1. NAME	<input type="text"/>		
	LAST NAME	FIRST NAME	MIDDLE NAME
	<input type="text"/> SUFFIX	<input type="text"/> MAIDEN NAME	
2. COMPLETE ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE	<input type="text"/> <input type="text"/> <input type="text"/>		
	CITY	STATE	ZIP CODE
3. TELEPHONE NUMBERS	HOME <input type="text"/> - <input type="text"/> - <input type="text"/>	OFFICE <input type="text"/> - <input type="text"/> - <input type="text"/>	
	CELL <input type="text"/> - <input type="text"/> - <input type="text"/>		
4. EMAIL ADDRESS	<input type="text"/>	5. SOCIAL SECURITY NUMBER	<input type="text"/>
6. DATE OF BIRTH	<input type="text"/> / <input type="text"/> / <input type="text"/> MONTH DAY YEAR		7. PLACE OF BIRTH
	<input type="text"/> CITY AND STATE OR PROVINCE OR COUNTRY		
8. NAME OF MEDICAL SCHOOL	<input type="text"/> INCLUDE CITY AND STATE OR PROVINCE OR COUNTRY (SUBMIT PHOTOCOPY OF YOUR DIPLOMA)		
9. TYPE OF MEDICAL DEGREE	MD <input type="text"/> YEAR GRANTED	DO <input type="text"/> YEAR GRANTED	MBBS or MBChB <input type="text"/> YEAR GRANTED
10. NAME OF DENTAL SCHOOL	<input type="text"/> INCLUDE CITY AND STATE OR PROVINCE OR COUNTRY (SUBMIT PHOTOCOPY OF YOUR DIPLOMA)		
11. TYPE OF DENTAL DEGREE	DDS <input type="text"/> YEAR GRANTED	DMD <input type="text"/> 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		TO DATES		YEAR LEVEL	NO. OF MONTHS	SPECIALTY
		MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR			
		/	/	/	/			
		/	/	/	/			
		/	/	/	/			
		/	/	/	/			
		/	/	/	/			
		/	/	/	/			
		/	/	/	/			

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		TO DATES		YEAR LEVEL	NO. OF MONTHS
		MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR		
		/	/	/	/		
		/	/	/	/		
		/	/	/	/		
		/	/	/	/		
		/	/	/	/		
		/	/	/	/		
		/	/	/	/		

NAME OF PROGRAM DIRECTOR

14. FELLOWSHIP(S) FOLLOWING PLASTIC SURGERY RESIDENCY.

NAME OF PROGRAM, CITY AND STATE OR COUNTRY	TYPE	FROM DATES		TO DATES		NO. OF MONTHS
		MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	
		/	/	/	/	
		/	/	/	/	
		/	/	/	/	

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 (Hepatobiliary) | 6. Surgical critical care |
| 2. Alimentary tract surgery (Colon and Rectal) | 7. Surgical oncology (non-breast) |
| 3. Oncologic Breast surgery | 8. Transplant |
| 4. Emergency medicine | 9. Trauma management |
| 5. Pediatric surgery | 10. 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
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

Continued from page 3 if needed.

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
25.				
26.				
27.				
28.				
29.				
30.				
31.				
32.				
33.				
34.				
35.				
36.				
37.				
38.				
39.				
40.				
41.				
42.				
43.				
44.				
45.				
46.				
47.				
48.				
49.				
50.				
51.				
52.				
53.				
54.				
55.				
56.				
57.				
58.				
59.				
60.				
61.				
62.				
63.				

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.