

## PROGRAM APPLYING FOR: ☐ Orthopaedic Physical Therapy fellowship ☐ Hand Therapy fellowship PERSONAL INFORMATION: First Name ΜI Last Name Current Street or PO Address Zip/Postal Code City State Work Mobile Telephone: Home Fax **EDUCATION:** College or University City/State/ Dates/ Degree/GPA (Physical or Occupational Therapy) College or University City/State/ Dates/ Degree/GPA College or University City/State/ Dates/ Degree/GPA PROFESSIONAL LICENSURE (INCLUDE ALL CURRENT AND PAST): License number License number \_\_\_\_\_State License number State

State

\_\_\_\_\_ License number

Employer/Title/Date(s)  Employer Title Date(s)	
Employer Title Date(s)	
Employer Title Date(s)	
RECOMMENDATIONS	
(Include three recommendations: one medical (MD or PA), one healthcare propersonal recommendation in a sealed envelope or mailed separately)	vider (PT/OT), and one
Name/Institution/Title/Phone	
Name/Institution/Title/Phone	
Name/Institution/Title/Phone	
CLINICAL FELLOWSHIP APPLICATION ESSAY	
Please write on separate paper and explain why you want to participate in the Fellowship Program. Please incorporate career goals and description of how you will contributed to these goals. Attach additional pages as needed. Please be contributed to these goals.	our clinical experiences have/
Please attach two copies of your curriculum vitae to this application.	
□ Application Check List □ Professional/Person	al references
□ Completed personal information □ Curriculum vita	
☐ Clinical fellowship essay attached	
HOW DID YOU HEAR ABOUT US:	
□ OC (OrthoCarolina) website □ AOTA website	
☐ ASHT website ☐ HTCC website	
☐ Internet search ☐ Other, please elaboration	rate

Signature of Applicant	ATOA Member #	Date
OFFICIAL USE ONLY		
Date received:	Signature:	
Date interviewed:	Signature:	
Date approved/disapproved:	Signature:	

**MAIL APPLICATION MATERIALS TO:** 

## **OrthoCarolina**

Attn: Stacy Rumfelt OTR/L, OTD, CHT, CLT 870 Summit Crossing Place Gastonia, NC 28054

704.671.1860 ph 704.671.1859 fax

YOU. IMPROVED.

