



## Columbia Orthopaedics Center for Hip & Knee Replacement

Fellowship Year of Interest: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Contact Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Evening Phone Number: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Are you a U.S. citizen?

- Yes: \_\_\_\_\_
- No: \_\_\_\_\_
  - Visa Status: \_\_\_\_\_
  - Country of Origin: \_\_\_\_\_

Please Submit the Following:

\_\_\_\_ Most Recent Curriculum Vitae

\_\_\_\_ OITE Scores

\_\_\_\_ USMLE Scores (Step 1, Step 2 CS/CK, Step 3)

\_\_\_\_ Two Letters of Recommendation

Recommender 1: \_\_\_\_\_

Recommender 2: \_\_\_\_\_

\*\*\*Please note\*\*\*

**New York State Licensure is required for the CHKR Clinical Fellowship**

---

After completion, please email to [wm143@columbia.edu](mailto:wm143@columbia.edu) or fax to: (212) 305-4024 or mail to:  
Center for Hip & Knee Replacement, 622 W 168<sup>th</sup> Street, PH 1155, New York, NY 10032.  
Questions? Call 212-305-8193