

## AANA FELLOWSHIP RECOGNITION PROGRAM PROGRAM REVIEW FORM

Instructions:

To the Program Director, please complete the following information. Use additional pages if necessary.

DEMOGRAPHICS			
Name of Program			
Location and Sponsoring Institution or Individual			
Office Address _____			
City _____ State _____ Zip _____			
Phone _____			
Program Director			
Director's Academic Affiliation and Titles			
Type of Fellowship: <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Sports Medicine <input type="checkbox"/> Knee <input type="checkbox"/> Other (please specify) _____			
Years in Existence	Duration in Months	Number of Positions	Annual Compensation
Sponsor or Provider of Compensation			
Medical Malpractice Provided By:			
Arrangement for Medical Meetings			
Vacation Allotment	Interview required		Decision date

## FACULTY

For each member of the faculty please provide the following information. Let a number correspond with each doctor throughout this page.

Name	Fellowship Title/Position	Undergraduate Institution & Degree	Medical School & Degree
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
Fellowship Training or Other Subspecialty Training		Board Certification and Year	
1. _____		_____	
2. _____		_____	
3. _____		_____	
4. _____		_____	
<b>Society Membership</b> (please check mark)			
1. <input type="checkbox"/> AANA <input type="checkbox"/> AAOS <input type="checkbox"/> AOSSM <input type="checkbox"/> ACSM <input type="checkbox"/> ISK <input type="checkbox"/> Other (please specify) _____			
2. <input type="checkbox"/> AANA <input type="checkbox"/> AAOS <input type="checkbox"/> AOSSM <input type="checkbox"/> ACSM <input type="checkbox"/> ISK <input type="checkbox"/> Other (please specify) _____			
3. <input type="checkbox"/> AANA <input type="checkbox"/> AAOS <input type="checkbox"/> AOSSM <input type="checkbox"/> ACSM <input type="checkbox"/> ISK <input type="checkbox"/> Other (please specify) _____			
4. <input type="checkbox"/> AANA <input type="checkbox"/> AAOS <input type="checkbox"/> AOSSM <input type="checkbox"/> ACSM <input type="checkbox"/> ISK <input type="checkbox"/> Other (please specify) _____			
Present Clinical and Academic Appointments			
1. _____			
2. _____			
3. _____			
4. _____			
Publications or Presentations in the Last Two Years			
1. _____			
2. _____			
3. _____			
4. _____			
Have hospital privileges or medical licenses ever been suspended at any institution? _____ If yes please explain.			

## CLINICAL PROFILE OF FELLOWSHIP

Let a letter correspond to each institution throughout this page.

List the outpatient and inpatient institutions which are a part of the program (For each outpatient facility indicate the total new patient case load and surgical case load within the most recent calendar year.)

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_
- D. \_\_\_\_\_

For each inpatient institution, indicate the total case load divided as follows:

Arthroscopy cases:	Shoulder	Elbow	Ankle	Wrist	Other (specify)
Knee					
A. _____	_____	_____	_____	_____	_____
B. _____	_____	_____	_____	_____	_____
C. _____	_____	_____	_____	_____	_____
D. _____	_____	_____	_____	_____	_____
Open cases:					
Knee					
A. _____	_____	_____	_____	_____	_____
B. _____	_____	_____	_____	_____	_____
C. _____	_____	_____	_____	_____	_____
D. _____	_____	_____	_____	_____	_____

Of the surgical case load please specify the number of cases for each faculty member for the most recent calendar year.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Describe the call requirements for the faculty and the Fellow and the Fellows responsibilities when on call:

## EDUCATIONAL OPPORTUNITIES

List the libraries available to the Fellow and the Fellowship program:

Describe the audio visual content of the fellowship program and other facilities for making and editing video tapes/slides:

List the regular conferences attended by the Fellow and his/her role in each as participant, organizer, or presenter:

Describe the teaching responsibilities of the Fellow to Allied Health personnel, medical students, residents, and other Fellows:

Describe the faculty participation in conferences:

Describe the laboratory facility available for anatomy and psychomotor skills:

Describe how teaching is accomplished:

Describe the mechanism for evaluation of performance:

Describe the purpose of the Fellowship and the objectives or goals of the Fellowship:

**RESEARCH OPPORTUNITIES**

Describe the facilities available for clinical investigation or basic investigation on arthroscopic topics:

Describe the requirements in the Fellowship for research such as preparation of manuscripts or presentation of work:

Describe the time allotted for research:

List the presentation or publication in the Fellowship for the last two years:

List the names and addresses of the last five Fellows with the dates of participation in the fellowship program and their current practice status. These fellows will be sent a graduate review form. These must be returned for the review process to be completed.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Does your fellowship program hold any acreditations? If so, please name.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Program Director*

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