APPLICATION FOR FELLOWSHIP

Attach Picture
Of Applicant Here

Jeffrey A. Fearon, M.D.

The Craniofacial Center
7777 Forest Lane, Suite C-700
Dallas, Texas 75230

Please fill in the following information completely.

BIOGRAPHICAL INFORMATION

1. LAST NAME	FIRST NAME	MIDDLE NAME	2. ❑ MALE ❑ FEMALE
3. DATE OF BIRTH	4. PLACE OF BIRTH	5. SOCIAL SECURTIY NO.	
6. CITIZENSHIP	7. MARITAL STATUS	8. SPOUSES NAME	
9. RESIDENCE ADDRESS			

10. HOME PHONE	11. WORK PHONE	12. CELLULAR PHONE	13. EMAIL ADDRESS

LICENSURE

14. DO YOU HAVE A TEXAS LICENSE (ENTER # HERE)	EXPIRATION DATE	15. NPI #:

16. CURRENT AND PREVIOUS LICENSURE IN OTHER STATES	DATE OBTAINED	LICENSE # / EXPIRATION
	DATE OBTAINED	LICENSE # / EXPIRATION
	DATE OBTAINED	LICENSE # / EXPIRATION

17. DEA #:	DEA EXPIRATION DATE	18. UPIN #:
19. SAN FRANCISCO MATCH #:		

EDUCATION AND TRAINING

20. COLLEGE/UNIVERSITY				
ADDRESS				
DEGREE OBTAINED			DATE ATTENDED	
21. MEDICAL SCHOOL				
ADDRESS				
22. ECMG# (FOREIGN MEDICAL GRADUATES:)			DATE	
23. INTERNSHIP ❑ Rotating	❑ Straight	❑ Other:	FROM TO	
HOSPITAL NAME		INTERNSHIP TRAINING DIRECTOR		
MAILING ADDRESS				
CITY			STATE	ZIP
24. RESIDENCY ❑ Medical	❑ Surgical	❑ Other:	FROM TO	
HOSPITAL NAME		RESIDENCY TRAINING DIRECTOR		
CITY			STATE	ZIP
25. RESIDENCY ❑ Medical	❑ Surgical	❑ Other:	FROM TO	
HOSPITAL NAME		RESIDENCY TRAINING DIRECTOR		
CITY			STATE	ZIP

BOARD CERTIFICATION

26. ARE YOU BOARD CERTIFIED?	❑ YES	❑ NO
27. ARE YOU BOARD QUALIFIED?	❑ YES	❑ NO

PROFESSIONAL ACTIVITIES AND APPOINTMENTS

28. INSTITUTION	TYPE OF APPOINTMENT
29. TEACHING OR RESEARCH ACTIVITIES:	
30. PROFESSIONAL OR HONORARY SOCIETIES:	

HEALTH STATUS

31. PLEASE NOTE ANY HOSPITALIZATIONS, MAJOR ILLNESSES, OR OTHER TYPE OF INSTITUTIONAL CARE FOR HEALTH PROBLEMS DURING THE PAST 10 YEARS.
32. PLEASE GIVE FULL DETAILS OF CURRENT OR PREVIOUS HISTORY OF PHYSICAL DISABILITY, MAJOR ILLNESS, DRUG OR ALCOHOL ABUSE (IF NONE, SO STATE).
33. DATE OF LAST PHYSICAL EXAM: PHYSICAL: PRESENT HEALTH STATUS:
34. DO YOU PRESENTLY HAVE A PHYSICAL OR MENTAL HEALTH CONDITION, INCLUDING ALCOHOL OR DRUG DEPENDENCE, THAT AFFECTS OR IS REASONABLY LIKELY TO AFFECT THE PROPER PERFORMANCE OF THE PRIVILEGES YOU HAVE REQUESTED? (IF YES, PROVIDE FULL EXPLANATION ON SEPARATE SHEET). YES NO

CRIMINAL ACTIVITY

35. HAVE YOU EVER BEEN ARRESTED, FINED (OVER $100), CHARGED WITH OR CONVICTED OF A CRIME, INDICTED, IMPRISONED, PLACED ON PROBATION, OR RECEIVED DEFERRED ADJUDICATION? (IF YES, PROVIDE FULL EXPLANATION ON SEPARATE SHEET). YES NO

REFERENCES

36. PLEASE LIST THREE REFERENCES WITH **COMPLETE** ADDRESSES, ONE REFERENCE MUST BE A PREVIOUS CHIEF/INSTRUCTOR OR DEPARTMENT CHAIRMAN/SUPERVISOR; AND ARRANGE FOR LETTERS OF RECOMMENDATION TO BE SENT:
NAME
ADDRESS
CITY, STATE ZIP
NAME
ADDRESS
CITY, STATE ZIP
NAME
ADDRESS
CITY, STATE ZIP

37. WHAT TYPE OF PRACTICE WOULD YOU IDEALLY LIKE TO HAVE FOLLOWING COMPLETION OF YOUR FELLOWSHIP?

DATE _____ SIGNATURE OF APPLICANT _____