



12 rue de Chaillot 75116 PARIS

Phone: +33 (0)1 84 130 470

www.parisshoulderunit.com

APPLICATION FORM – VISITOR FELLOWSHIP

Chairman: Ph. VALENTI, MD

PERSONAL INFORMATION

Last Name:

First name:

Birth date: __/__/----

Marital situation:

Children: Yes No If yes, number: ____

Address:

City:

Zip Code:

Country:

Nationality:

Languages spoken:

- Mother tongue:

- Other:

.....

WORK INFORMATION

Work Address:
.....

Work Phone:

Email:

Visitor fellowship period required (*1 or 3 months*):

- 1st choice: *from*.....*to*.....
- 2nd choice: *from*.....*to*.....
- 3rd choice: *from*.....*to*.....

DOCUMENT ATTACHED TO THE APPLICATION FORM:

- 2 pictures (*one for the application and the other for the institute's web site*)
- CV (*specify the Institution, city/country, dates of medical studies, date of medicine diploma, date of speciality diploma*)
- Cover letter
- References
- Recent publications

Please fill and send this application form with all the documents to

Dr Philippe VALENTI

philippe.valenti@parisshoulderunit.com

and to

Ms Imen NID TAHAR

imen.arc@parisshoulderunit.com