



Edward Via College of  
Osteopathic Medicine

**AUBURN**

# VCOM Sports Medicine Fellowship Application

Edward Via College of Osteopathic Medicine - Auburn Campus  
910 South Donahue Drive, Auburn AL 36832  
Phone: 334-442-4000 • Fax: 334-442-4095

**Siraj Abdullah, DO, CAQSM**, Program Director  
**Lakiesha Young Hicks**, Program Coordinator Auburn Campus  
[lyounghicks@auburn.vcom.edu](mailto:lyounghicks@auburn.vcom.edu)

Date:	
Name:	
Address:	
State/Province:	
Zip/Postal Code:	
SS Number:	
Email:	
Home Phone:	
Cell Phone:	

Please attach recent photograph

Please select preferred campus:

Virginia     Auburn

For academic year:

## Military Service Obligation/Deferment?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Years
<b>Military Branch:</b>		
<b>Other Service Obligation:</b>		<b>Description</b>

<b>Citizenship:</b>		<b>If not US Citizen, Visa Type:</b>	
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**State Medical Licenses:**

Type	Number	State	Exp. Date

Has your license ever been revoked?  yes  no    If yes, please explain in the additional comments section

**Education**

Type of School	Name of School and Complete Mailing Address	Years Completed	Major or Degree
College/University			
Medical School			
Professional School			

Have you ever been convicted of a crime?     Yes     No

If yes, please explain:

Do you have a driver's license?     Yes     No

State of issue:

<b>Have you had any accidents in the past 3 years?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>How many?</b>	
<b>Have you had any moving violations in the past 3 years?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>How many?</b>	

## Internship/Residency:

1.

Internship:

Program Director:

Dates of internship:

From:

To:

Complete Address:

Phone #

Rotations:

Discipline:

Reason for leaving:

2.

Internship:

Program Director:

Dates of internship:

From:

To:

Complete Address:

Phone #

Rotations:

Discipline:

Reason for leaving:

**Have you ever had any interruption in your training (undergraduate through residency)?**

**Yes**       **No** – if yes, please explain in the additional comments section

**Sports Medicine Rotations**

Please list dates, type, location, instructor:

**Sports Medicine Coverage (Games, Events, Training Room, Other)**

Please list dates, type, location, instructor:

**Sports Medicine Conferences**

Please note attended/presented

**Previous Practice Experience**

	Examination:	Status	Date:	Score (3/2 digits):
I				
II				
III				

**Medical Licensure:**

ACLS  Yes  No

Exp. Date

PALS  Yes  No

Exp. Date

DEA Reg #

Exp. Date

Board Certification

Yes  No

Name

Medical License Problem?  Yes  No Reason

Ever named in a malpractice suit?  Yes  No Reason

Past History:  Yes  No Explanation

**Education Commission for Foreign Medical Graduate Certification:**

ECFMG Certified:  Yes  No Certification Date

**Honors/Awards:**

**Previous Employment (list up to 3)**

1.

Name of Employer:

Name of last Supervisor:

Dates of Employment:

<b>From: Date</b>	<b>To: Date</b>
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Salary

<b>Beginning:</b>	<b>Ending:</b>
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Complete Address:

Phone #:

Last job title:

**Reason for leaving (Be Specific!)**

**List jobs held, duties performed, skills used or learned, advancements, or promotions while employed:**

May we contact this employer?  Yes  No

2.

Name of Employer:

Name of last Supervisor:

Dates of Employment:

From: Date

To: Date

Salary

Beginning:

Ending:

Complete Address:

Phone #:

Last job title:

Reason for leaving (Be Specific!)

List jobs held, duties performed, skills used or learned, advancements, or promotions while employed:

May we contact this employer?  Yes  No

3.

Name of Employer:

Name of last Supervisor:

Dates of Employment:

From: Date

To: Date

Salary

Beginning:

Ending:

Complete Address:

Phone #:

Last job title:

Reason for leaving (Be Specific!)

List jobs held, duties performed, skills used or learned, advancements, or promotions while employed:

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May we contact this employer?  Yes  No

**Please list 3 references:**

	1	2
Telephone		
Name		
Position		
Company		

	3
Telephone	
Name	
Position	
Company	

**Additional Comments:**

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**Certification Statement:**

I have read and understand the instructions and other information of this application. I certify that the information recorded herein is complete and accurate to the best of my knowledge. I recognize that any intentional misrepresentation on my part may cause me to be disqualified from continuation in the application process and/or to be denied appointment to or dismissal from the medical education program.

I hereby authorize VCOM, its staff and their representatives, to consult with my peers and others who may have information bearing on my current professional competence, character, health status, ethical qualifications and ability to work cooperatively with others and consent to the release of such information to and by them.

I further consent to the inspection, by VCOM, its staff and their representatives, of all documents that may be material to an evaluation of my qualifications and current competencies and consent to the release of such information to them.

**Applicant Signature****Date**

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Trainees are selected on the basis of academic and personal qualifications regardless of race, sex, color, religion, national origin or marital status.