

**Johns Hopkins University School of Medicine  
Department of Orthopaedic Surgery  
ASTP (Advanced Specialty Training Program) Application**

Please note that this is a preliminary universal application form for all ASTP programs in the Department of Orthopaedic Surgery at Johns Hopkins Medical Institutions. This includes Sports Medicine, Spine, Arthritis and Total Joints. All programs, with the exception of Spine, begin August 1 and end July 31. The Spine program runs from July 1 to June 30. All programs are one (1) year in length. Please complete this application neatly in black ink or type. Return application with personal statement, copy of CV, medical school transcript and USMLE scores to program director specified on reference page.

**Personal Information**

Name \_\_\_\_\_  
                     Last  First  Middle

Present Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone # (work) \_\_\_\_\_ (home) \_\_\_\_\_  
                     (cell) \_\_\_\_\_ (pager) \_\_\_\_\_

SS# \_\_\_\_\_ Citizenship \_\_\_\_\_

**Emergency Contact Information (other than spouse)**

Name \_\_\_\_\_ Address \_\_\_\_\_

Telephone # \_\_\_\_\_

**Education**

**Undergraduate**

School	Dates Attended (To/From)	Area of Study/Honors	Degree/Date of graduation

**Graduate, including medical school**

School	Dates Attended (To/From)	Area of Study/Honors	Degree/Date of graduation

**Post Graduate Training**

Program Site	Dates (To/From)	Specialty/Program Director Name
1		
2		
3		
4		
5		

**Research Experience (please attach copies of published papers based on research)**

Program Site	Dates	Type of Research /Preceptor Name

**Presentations**

Topic	Dates Presented	Where Presented

**Grant Experience**

---

---

---

---

**Examinations**

Exam	Date	Score Pt. 1	Pt. 2	Pt. 3
USMLE				
ECFMG				
FLEX				
D.O.				

**Board Certification**

Board Name \_\_\_\_\_ Year \_\_\_\_\_

Board Name \_\_\_\_\_ Year \_\_\_\_\_

**Licensure (attach copies of current and past)**

State	License #	Exp. Date

Have there been any restrictions, disciplinary actions placed on you in any state where you are licensed? \_\_\_\_\_  
If yes, please explain \_\_\_\_\_

Do you have any health problems that would affect your clinical performance or abilities?\_  
If yes, please explain \_\_\_\_\_

**Military or Government Service**

Branch \_\_\_\_\_ Dates \_\_\_\_\_

Current Status \_\_\_\_\_ Future Obligations \_\_\_\_\_

**Special Interests/Abilities (recreational/athletic)**

---

---

## References

**(Should be sent directly to Program Director at address listed below)**

Please obtain four (4) professional references including one from a surgeon in the sub-specialty field in which you are applying and one from your Residency Program Director. The letters should address the following:

1. How would you rank (%) the applicant in his residency over the fast five years compared to all other residents during that time period?
2. Are you aware of any paraprofessional or peer conflicts that have occurred with the applicant?
3. Is the applicant skillful and careful? Would you trust him with one of your patients?
4. If you have more than one applicant applying for this specific sub-specialty, how does each rank compared to the others?

**Applicant should indicate below to which program he/she is applying and give copies of this sheet to reference letter writers**

Letters of reference should be sent to:

\_\_\_\_\_ Arthritis/Total Joints (Johns Hopkins/Good Samaritan Hospital)  
Send to: Robert M. Peroutka, M.D.  
1300 York Road, Suite 100  
Lutherville, MD 21093

\_\_\_\_\_ Spine (Johns Hopkins Hospital)  
Send to: Lee Riley III, M.D.  
JHOC 5<sup>th</sup> Floor  
601 N. Caroline Street  
Baltimore MD 21287-0881

\_\_\_\_\_ Sports Medicine (Johns Hopkins Hospital/Johns Hopkins at Greenspring)  
Send to: Andrew Cosgarea, M.D.  
Edward McFarland, M.D.  
10753 Falls Rd. #215  
Lutherville MD 21093