



The Society of Neurological Surgeons

Application for Accreditation of Neurologic Surgery Subspecialty Fellowship

BASIC INFORMATION AND PARTICIPATING INSTITUTIONS

Fellowship/Subspecialty:

Fellowship Director Name:

Title:

Mailing Address:

Telephone:

Sponsoring Neurosurgery Training Program:

Address:

Telephone:

Chairman of Department:

Is the Neurosurgical unit a separate department or division of Surgery? _____

SPONSORING PROGRAM INFORMATION

ACGME Accredited neurosurgical program? Yes No

Other Accreditation
of Residency _____

Program Status as of Last RRC Survey:

Full Accreditation

Date of Accreditation _____

Provisional Accreditation

Probationary Accreditation

Approved Resident Complement (e.g. 1-1-1-1-1):

Next scheduled RRC survey date:

Total Number of Neurosurgical Residents Currently on Site and Level:

NS-1: _____ NS-2: _____ NS-3: _____ NS-4: _____ NS-5: _____ NS-6: _____ NS-__: _____

Other institutional neurosurgical fellowships (specify # of fellows in each and duration of each fellowship):

_____ RRC Acknowledged? Yes No SNS Accredited? Yes No

_____ RRC Acknowledged? Yes No SNS Accredited? Yes No

_____ RRC Acknowledged? Yes No SNS Accredited? Yes No

_____ RRC Acknowledged? Yes No SNS Accredited? Yes No

Total Number of Neurosurgical Subspecialty Fellows on Site Annually (specify subspecialty area and level of fellows):

- Append annualized institutional/program operative data for preceding academic year. (Use RRC format)
- Append annualized operative data (all cases) for the most recent graduated fellow(s) in this subspecialty.
- A processing fee of \$350 payable to CAST/SNS is required for each application. Completed applications should be submitted to the Secretary of The Society of Neurological Surgeons.

PRIMARY CLINICAL SITE (Institution #1):

Street Address:

City, State, Zip:

Telephone:

Medical School Affiliation, if any:

On Site Fellowship Training Director:

Months Fellow on Service:

PARTICIPATING INSTITUTION (#2)

JCAHO Approved: Yes No

Relationship with Sponsoring Neurosurgery Program: Affiliated Integrated

Street Address:

City, State, Zip:

Telephone:

Distance between this institution and primary clinical site (Site #1):

Travel time in miles: _____ Travel time in minutes: _____

Medical School Affiliation, if any:

On Site Training Director: Full-time: Part-time: Voluntary:

Months Fellow on Service at this site:

Rotations to this Site: Elective Required

Attach affiliation agreements for this specific fellowship for each participating institution.

PARTICIPATING INSTITUTION (#3)

JCAHO Approved: Yes No

Relationship with Sponsoring Neurosurgery Program: Affiliated Integrated

Street Address:

City, State, Zip:

Telephone:

Distance between this institution and primary clinical site (Site #1):

Travel time in miles: _____ Travel time in minutes: _____

Medical School Affiliation, if any:

On Site Training Director: Full-time: Part-time: Voluntary:

Months Fellow on Service at this site:

Rotations to this Site: Elective Required

Attach affiliation agreements for this specific fellowship for each participating institution.

I have personally reviewed the information provided on these forms and attest to their accuracy.

Signature of Fellowship Director:

Date:

I have personally reviewed the enclosed application for this Neurosurgical Fellowship program and support the application.

I have enclosed a letter outlining:

1. interactions between the residency and the fellowship
2. support of the fellowship by the department/division
3. interactions between the department and the fellowship

Signature of Department/Division Chair:

Date:

FELLOWSHIP ORGANIZATION AND STRUCTURE

1. Duration of Fellowship in months:

2. Number of Fellowship positions requested:

3. Identify Fellows currently in the program (this subspecialty only), former neurosurgery training affiliations and completion dates:

Name	Former Neurosurgery Training Affiliations	Completion Date (month/year)
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Fellowship Faculty:

Director:	State License? Yes/No	ABNS Certification Year	Participation Full or Part time	% Practice in Subspecialty
_____	_____	_____	_____	_____

Associate Faculty:	State License? Yes/No	ABNS Certification Year	Participation Full or Part time	% Practice in Subspecialty
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Specify process by which the fellowship director is appointed:

Is Fellowship Program Director responsible to Neurosurgical Chair/Training Program Director? _____

STRUCTURE:

Describe the structure of the Fellowship Program over its entire duration, including all clinical responsibilities at each training site, applicable conferences and didactic teaching and opportunities/responsibilities for research. Elaborate on other specialties involved in fellowship training or multidisciplinary roles. Also include the role of the Fellow(s) for education/training of programs core residents and extent of Fellow(s) involvement in non-fellowship related patient care, if any.

GOALS & OBJECTIVES:

Provide a written statement of the educational Goals and Objectives of the Fellowship.

SUPERVISION:

Provide a written description of supervisory mechanism for fellows.

EVALUATIONS:

Describe evaluation mechanisms used for fellows and for fellow's evaluation of the fellowship and faculty.

IMPACT STATEMENT:

Describe the potential impact of the fellowship on residency and resident training and safeguards for protection of training opportunities for the program's core residents.

If more than one fellow per year, describe the interactions and safeguards for individual fellow training opportunities.

FELLOWSHIP DIRECTOR'S CREDENTIALS

Institution:

Name:

Faculty Rank:

Hospital Position:

Education:

Medical School of Graduation and Year:

Internships and Year:

Residency and Year(s):

License Number and ABNS Certificate Number:

Date of ABNS Certification:

Date Current Appointment Began:

Clinical Subspecialty Training and Experience:

Clinical, Educational and Administrative Experience:

Research Training and Experience (list past and active grant funding):

Membership in Medical Organizations (list):

Publications (list):

FELLOWSHIP FACULTY CREDENTIALS

Institution:

Name:

Faculty Rank:

Hospital Position:

Education:

Medical School of Graduation and Year:

Internships and Year:

Residency and Year(s):

License Number and ABNS Certificate Number:

Date of ABNS Certification:

Date Current Appointment Began:

Clinical Subspecialty Training and Experience:

Clinical, Educational and Administrative Experience:

Research Training and Experience (list past and active grant funding):

Membership in Medical Organizations (list):

Publications (list):