Long-term Fellowship Application Form

First name: _____

Last name: _____

Birth date: _____ Nationality: _____

Department / Hospital / Institute: _____

_____

Address: _____

Code / City / Country: _____

Phone: _____

E-mail: _____

Languages spoken: _____

Expected duration of fellowship is granted : 12 months _____

Please indicate the most convenient date(s). Note, that the months of July and August are not recommended due to summer leave:

Do you have any preferred Spine Center, you would like to visit:

1st choice: _____

2nd choice: _____

3rd choice: _____

I have read the IGASS Fellowship guidelines and accept all conditions.

Place, Date:

Signature: _____