Fellowship Guidelines

ABMSS's commitment to all of its patients includes the development of future medical volunteers to continue the delivery of care. Also of great importance is the investment in research on cleft lip/palate, to better understand the condition and to improve treatment.

Under the fellowship, Qualified surgeons are offered the opportunity to attend and train at our cleft centres where they will gain invaluable experience working alongside experienced ABMSS medical professionals.

Fellow profile

- Qualified Oral and Maxillofacial surgeons (OMFS), ENT surgeons, & Plastic and reconstructive surgeons of Good standing can apply for the fellowship.
- Candidates must demonstrate an interest in rendering services at Cleft centres, Conducting camps , engaging in conducting research related to the field of cleft and craniofacial anamolies.
- A letter of recommendation from senior faculty member of ABMSS/AOMSI/ APSI/ AOI must attest to the resident's personal and professional strength.

Expectations of fellows

- Fellows will abide by the Cleft programme Documents/Curriculum/Instructions given to them by centre directors , & agree to attend any ABMSS cleft missions if any, and may be invited to attend an annual ABMSS conference for scientific presentations.
- Fellows will agree to full responsibilities of team membership. This includes agreeing to the code of conduct for fellows handed over to them by centre directors.
- During the Fellowship, fellows will be assigned specific responsibilities according to their speciality, past training and skill set as deemed fit by cleft centre director .
- Fellows will be required to submit their work log, a brief experience statement and some pictures about their surgical work at the end of fellowship.

ABMSS

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Name:_____

(First name) (Middle name) (Last name)

Gender: Male (___) Female (___) Home phone(____)_____

Mobile phone: (_____)_____ Fax: (___)_____

(Please include country code and area code for phone nos.)

E-mail: _____

Home address: _____

City: _____State: _____Zip:_____ Country:_____

Employer:_____

Work address:_____

City: _____State: _____Zip:_____ Country:_____

Preferred mailing address (check one): _____Home address _____ Work address

REQUESTED TRAINING CENTRE: Please indicate your preferences:

Tentative Date for starting-

1. CENTRE 1ST CHOICE:

2. CENTRE 2ND CHOICE:

DISCIPLINE: Please indicate if subspecialty within your field. Examples (OMFS, ENT SURGEON, PLASTIC SURGEON.etc..)

Subspecialty_____

Subspecialty_____

ABMSS

CURRENT EXPERIENCE: Please check areas of experience during your training programme. Check all that apply

___Paediatrics (0-6 years old) _Youth (7-14 years old)

___Adult (over 14 years old) _____Geriatric (Over65 yrs)

Please provide details and dates of any fellowships you are currently in or have completed:

_____

_____

Subspecialty Training:	Hospital
Cleft Lip	
Craniofacail	
Microsurgery	
Head and Neck Oncology	
Other	

Board certificate ☐ YES Specialty:_____ Date:_____ ☐No

Day/Month/Year

Have your medical privileges ever been suspended? Yes ☐ No☐

If yes, please explain: _____

_____

ACTIVE STATE REGISTRATION NUMBER -

Preferred but not required:

BLS Certification : Yes ☐ No☐ Certification Date: _____

Day /Month /Year

ACLS Certification : Yes ☐ No☐ Certification Date: _____

Day /Month /Year

DOCUMENTS REQUIRED:

1. CV with 2 copies of latest PP
2. Degree Certificate
3. Active State Council Registration certificate

4. BLS/ ACLS certificate if available.
5. Professional Indemnity and personal Medical Insurance copies
6. Letter of Recommendation
7. Any other achievements.

Please have letters of advocacy addressed to Dr. Jayanth BS, Director of Programmes and Medical Advisor. All recommendation letters should be printed on institution's letterhead/Personal letterhead of the recommending Surgeon.

ALL REQUIRED DOCUMENTS MUST BE SENT WITH COMPLETED APPLICATION

Incomplete packages will result in placement delays.

Applicants will receive email notification of application results.

Completed application packets will be sent to Dr. Jayanth BS, Director, Programmes and Medical Advisor, for review, at which time you may be interviewed by telephone or asked to submit additional information. ABMSS will inform you of the results of your application. Participants join the programme as an ABMSS volunteer. All expenses related to programme will be covered by fellowship funding unless otherwise indicated.

Participation on a medical mission is a privilege and an honour. Fellows regularly report it is one of the most intense, powerful and life changing events they have ever experienced. The application is your key to that experience.

Please scan all documents and e-mail them to Dr. Jayanth BS: jayanth.b.s@spaltkinder.org

Or mail them to: **ABMSS**, C4, Metro Business Centre #756, 80 feet Road, Koramangala, Bengaluru-560034, Karnataka

I have read the above and certify that the foregoing is true, correct and complete. I shall promptly inform **ABMSS** if there is any change to the facts herein.

Signature_____ Date: _____/_____/_____/

DAY MONTH YEAR