American Association of Neurological Surgeons

AANS European Training Course Application

Application Deadline: July 1, 2019 **Date of Application: _____**

This application is for consideration to participate in the European Association of Neurosurgical Societies (EANS) Training Course focused on Tumor **February 2-5, 2020,** in **Sarajevo, Bosnia and Herzegovina**.
Decisions will be announced by **August 30, 2019**.

Applicant Criteria

Applicants must:

- Be a neurosurgical resident, PGY 4-7, when the course occurs and in good standing.
- Be a member of the American Association of Neurological Surgeons (AANS).
- Be willing to obtain country-specific visa for travel.
- Include a copy of current curriculum vitae (CV).

Program Criteria

Programs must:

- Be ACGME accredited.
- Be CAST or ACPNF accredited or currently in the application process.
- Provide a letter of reference from the department chair, including a commitment to give the resident time off to attend the course.
- Include a letter of reference from the program director, which indicates the resident is in good standing.

Applicant Institution Information

Institution Name _____

Federal ID # _____

Institution Address: _____
Street Address

_____
City *State* *ZIP Code*

Institution Phone _____ Contact Email _____

Is the applicant's institution not-for-profit? YES ☐ NO ☐

If no, provide the name of affiliated non-profit entity : _____

Does your institution have an accredited ACGME residency program? YES ☐ NO ☐

Is your institution CAST or ACPNF accredited? YES ☐ NO ☐ Date of accreditation? _____

More information about the Society of Neurological Surgeon's Committee on Accreditation of Subspecialty Training (CAST) can be found at www.societyns.org/fellowships/index.asp

If no, has your institution applied for CAST or ACPNF accreditation? YES ☐ NO ☐ Date of application? _____

Applicant Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Current PGY (PGY 3-6; Must be PGY 4-7 at time of course): _____

Program Director Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Department Chairperson Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Applicant Experience

List your top three clinical interests

1 _____

2 _____

3 _____

List your authored and co-authored work (maximum five)

1 _____

2 _____

3 _____

4 _____

5 _____

Previous funding received for projects

Project Name _____ Funding Type _____

Project Name _____ Funding Type _____

Project Name _____ Funding Type _____

Previous volunteer roles

Volunteer Position _____

Volunteer Position _____

Volunteer Position _____

Are you a member of the American Association of Neurological Surgeons (AANS)? YES ☐ NO ☐

Are you a member of any other neurological society? YES ☐ NO ☐

If yes, which one(s) _____

Are there any dates in 2020 when you are unavailable? YES ☐ NO ☐

If yes, which dates _____

Do you have any known travel restrictions? YES ☐ NO ☐

If yes, what is the restriction _____

Disclaimer and Signature

I have reviewed this application for a Neurosurgery Research and Education Foundation (NREF) grant for participation in the EANS/AANS Resident Education Exchange Program and, to the best of my knowledge, the information enclosed is accurate. I agree to release and hold harmless the NREF, the American Association of Neurological Surgeons (AANS), its members, officers, and agents from any complaints or claims or demands for damage or otherwise, by reason of any act of omission or commission that they, or any of them, may make in connection with this application, including but not limited to the evaluation of the application and the final decision with respect to its approval and/or funding. It is understood and agreed that the decision as to whether the application qualifies for approval and/or funding rests solely and exclusively in the NREF Board of Directors and NREF Education Committee and that their decision is final. I understand that I will be legally bound by the foregoing.

Applicant Name _____ Signature _____ Date _____

I certify, on behalf of the applicant, that the statements herein are true, complete, and accurate to the best of my knowledge, and accept the obligation to comply with AANS and NREF's terms and conditions if application is approved and accepted based on information presented here within. I further certify that the applicant understands that any deliberate omission, misrepresentation, or falsification of any of the information contained in this application or in any other communication by the applicant to AANS/NREF related to this application may void acceptance to attend EANS course via AANS exchange program to the applicant institution by AANS/NREF and may require the applicant institution to refund any related expenses. By signing below, I attest that the program will grant the applicant time to attend and participate fully in the EANS course applied for if application is approved.

Program Director Name _____ Signature _____ Date _____

Department Chair Name _____ Signature _____ Date _____

Please submit completed application to the Neurosurgery Research & Education Foundation c/o Kathleen A. McMichael at kam@nref.org.