

Research Fellowship Application

**Application Instructions:** mail to fellowship@ihu-strasbourg.eu with supporting documents

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| **APPLICANT INFORMATION**  |
| Last Name  | First name | Date of Birth | Date of Application |
| Address  | City | Zip | Country |
| Phone  | E-mail Address |
| **EDUCATION :****☐ Surgeon ☐ Gastroenterologist ☐ Radiologist ☐ Engineer ☐ Other: …………………………………** |
| **PRIMARY INTEREST: ☐ Surgical Research ☐ Innovation/medical technology development** |
| University:  |
| Period:  | Graduate: **☐** Y ☐ N  | Degree:  |
| **POST GRADUATE TRAINING**  |
|  |
| **CURRENT POSITION**  |
| Institution:Location: | Dates:  |
| MEDICAL LICENSURE if applicable |
| Country/State:  | Date Issued: |
| LANGUAGES |
|  | Read | Spoken | Written |
| French | **☐** | **☐** | **☐** |
| English | **☐** | **☐** | **☐** |
| Other (please specify) | **☐** | **☐** | **☐** |

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| **RESEARCH**  |
| **What specific area(s) do you wish to work with in Research?** (*Education, fundamental research, clinical research, medical devices, innovative image guided procedures, hybrid surgery, etc.) Please provide details.* |
| **What are the key questions you want to answer with your research project? Please detail your research plan**.(*Background, aims, methods and potential impact of the research proposed)* |
| PROPOSED START DATE AND LENGTH OF FELLOWSHIP |
| **Duration:** [ ] 1 year [ ] 2 years**DATES:** From …………… …….To …… ………………………………….. |
| FUNDING |
| **Is partial or full funding available to you in support of a Fellowship appointment?** [ ]  **Yes** [ ]  **No** If yes, please indicate amount and source:  |