The Academy Of Minimally Invasive Foot & Ankle Surgery

FELLOWSHIP APPLICATION FORM

Application Fee $125.00

See other fees listed on Page 3

Name: _____

Office Address: _____

City: _____ **State:** _____

Zip Code: _____ **Date of Birth:** _____

Telephone: _____ **Fax:** _____

Email Address: _____

Degree: _____

State License: _____

Pre-Medical Education

College or University: _____

No. Of Years Attended: _____

Degree: _____

Date of Graduation: _____

Medical Education

College: _____

No. Of Years Attended: _____

Degree: _____

Date of Graduation: _____

Post-Graduate Surgical Training including Minimal Invasive, Preceptorships, Internships, & Residency

Location: _____

Dates: _____

Length of Time: _____

Surgical Experience in Minimal Invasive Surgical Procedures

_____

_____

State Licenses and Numbers

1) _____

2) _____

3) _____

4) _____

5) _____

☐ **I agree to abide by The Academy Of Minimally Invasive Foot & Ankle Surgery's Mission Statement, Preferred Practice Guidelines and Standards of Care.**

Signed: _____ **Date:** _____

Signature of Applicant

Please include a clear copy of a photo ID. Example: Driver's License, Passport

FELLOWSHIP

Please be advised that acceptance as a fellow in the Academy is conditional upon the following:

- Satisfactory proof of performance of 3 soft tissue cases and 5 bone surgery cases of ambulatory foot surgery, on an out-patient basis. You should submit these 8 case history reports to the National Office, at which time they will become the property of the Academy.

- A personal interview as desired by the Membership Committee. Questions may be asked concerning MIS instrumentation, goals of AMIFAS, general and specific criteria for MIS procedures and understanding of Preferred Practice Guidelines.

- Approval of the AMIFAS Board.

FEES

The annual dues are $495.00 per year for all Members including Fellowship members. To be considered for a fellow you must be current on your annual dues. There is a one-time new Fellow application fee of $125.00.

The Academy is contributing in a significant manner to the development of improved techniques and the enhancement of the image of foot surgery in the eyes of the public. We hope that you will become a Fellow and assist us in the attainment of our goals.

INSTRUCTIONS FOR CASE HISTORIES TOWARDS FELLOWSHIP

1. Please keep a copy of your case history packet for your records.

2. Documentation of performed procedure being reported via copies of:

- Pre and Post Op Radiographs.
- All procedures must be Ambulatory.
- Osseous procedures to be performed by Minimal Invasive Surgery.
- E.M.O.B for undocumented procedures.
- Pre & Post Op labeled photograph of reported procedure.
- Pathology report (Osseous & Soft Tissue).

3. Post-op progress notes should be a summary of the healing process of the patient by date; include when patient was able to return to a normal daily routine.

4. Required to:

- Present 5 Osseous Procedures (via Minimal Invasive Surgery).
- Present 3 Soft Tissue Procedures.
- Participate in 2 Surgical Cadaver Seminars on Minimal Invasive Surgery.
- Upon completion, there will be an oral and practical demonstration at a Cadaver Seminar.

5. Send your completed application and processing fee in the amount of $125.00 by check to the address below:

AMIFAS
3707 S Grand Blvd, Suite A
Spokane, WA 99203
Toll Free: 1-800-479-4936 Direct Phone: 509-624-1452
Fax: 509-624-1128

PATIENT INFORMATION SHEET

LIST CASE HISTORY REPORTS THAT OCCURRED WITHIN THE LAST TWO YEARS

PATIENT NAME:	SURGERY PERFORMED:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

THIS FORM IS TO BE INCLUDED WITH THE CASE HISTORY REPORTS.

CASE HISTORY REPORT

REPORT #: _____

PATIENT NAME: _____

AGE: _____

RACE: _____

SEX: _____

SURGERY: _____

_____

SURGICAL FACILITY: _____

CHIEF COMPLAINT: _____

_____

HISTORY AND PHYSICAL: _____

_____

_____

PREVIOUS TREATMENTS: _____

_____

DURATION OF CONDITION: _____

COMPLETE OBJECTIVE PICTURE OF PATIENT'S SURGICAL PROBLEMS: _____

_____

_____

_____

PRE-OPERATIVE DIAGNOSIS: _____

_____

_____

_____

PRE-OPERATIVE MEDICATIONS: _____

_____

_____

_____

POST OPERATIVE DIAGNOSIS: _____

_____

_____

POST OPERATIVE MEDICATIONS: _____

_____

_____

OPERATIONS PERFORMED (LIST ALL PROCEDURES): _____

_____

_____

_____

_____

_____

LABORATORY REPORTS (PATHOLOGY, TISSUE, BLOOD, URINE, etc.):

_____

_____

_____

_____

X-RAY FINDINGS: _____

_____

_____

_____

_____

PLEASE ATTACH OPERATIVE REPORTS (STANDARD FORMS ACCEPTED)

PLEASE SUBMIT PRE-OP X-RAYS, IMMEDIATE POST-OP X-RAYS, AND FINAL POST-OP X-RAYS SAVED ON A FLASH DRIVE WITH THEM NUMBERED ACCORDING TO THE PATIENT INFORMATION SHEET.

***MAKE SURE THAT NO PATIENT INFORMATION IS ON THE X-RAYS**

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