



Pacific Islands Orthopaedic Association

Training application

Name: _____

Date of birth: ____/____/____

Email address: _____

Phone: (____) _____

Current Hospital: _____

Country: _____

Medical school: _____

Graduating year: _____

Referees:

1. Name: _____

Email / phone: _____

2. Name: _____

Email / phone: _____

3. Name: _____

Email / phone: _____

Please include a CV listing all prior medical jobs and courses. Please also include a current passport style photo and some form of photo ID.