



## Orthopaedic Surgery & Sports Medicine Teaching & Research Foundation

Dear SOAR Applicant:

Thank you for your interest in my program created expressly for students interested in orthopaedics and research—aka SOAR. This educational program exposes interested and motivated undergraduate and pre-med students to orthopaedic surgery and research. The one-year program allows students to explore the fields of clinical practice and medical research while gaining valuable experience to help them make career decisions and support their application to medical school. The SOAR program is sponsored by the Orthopaedic Surgery and Sports Medicine Teaching and Research Foundation (OTRF).

SOAR positions are highly sought after so applicants are chosen based on merit. To apply, please complete the attached application form.

To be considered for the Soar Program, I must receive your application by April 1 of the SOAR academic year that begins June 1. Please make sure to fill it out completely and provide all the requested information. Incomplete or late applications will be ineligible.

Thank you for your interest in the SOAR Program.

Sincerely,



Steven C. Chudik, M.D.



### SOAR Program Application

Name: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate/Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Other Special Credentials/Certifications/Awards: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Training/Educational Background (please include school, location, dates of completion, and degree earned):

• High School: \_\_\_\_\_

\_\_\_\_\_

• Undergraduate: \_\_\_\_\_

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• Medical School: \_\_\_\_\_

\_\_\_\_\_



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Relevant Clinical/Research/Professional Experience (Please include length of time):

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Other Special Relevant Experiences You Would Like to Share (Use separate sheet if more space is needed):

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References for Letter of Recommendation:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Relationship: \_\_\_\_\_

How long have you known this person? \_\_\_\_\_

Please submit a short, one-page essay about your interest in this program, your goals for the experience and your future plans after completing the program.



I certify that all information submitted in the application process, including the application, transcripts, proof of licensure and certification (application), and all supplemental material is my own, factually true and honestly presented.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Orthopaedic Surgery & Sports Medicine  
Teaching & Research Foundation

**Send completed information and required documents to:**

OTRF SOAR Program  
c/o Dr. Steven Chudik, MD  
1010 Executive Court, Suite 250  
Westmont, IL 60559

Fax: 630-920-2382  
Email: [contactus@chudikmd.com](mailto:contactus@chudikmd.com)