**Application for Fellowship in Regional Anesthesiology and Acute Pain Medicine**

Desired fellowship start date: ____________________

______________________________________________________________________
First Name Middle Name Last Name

Previous Last Name: ______________________ Preferred Name: ____________________________

Email: ____________________________________________________________________________

SSN: __________________________________ Canadian SIN: ______________________________

Other ID# (type)____________________________________________________________________

**Present Mailing Address:**

Country: _________________Street Address: ____________________________________________

City: ____________________________ State/Province: ___________________ Zip Code: ________

**Future Mailing Address** *(if applicable)*: Beginning date ____________________________________

Country: _________________Street Address: ____________________________________________

City: ____________________________ State/Province: ___________________ Zip Code: ________

Preferred # (check one):

Home Phone: __________________ ☐

Work Phone: __________________ ☐

Pager: ________________________ ☐

Mobile: _______________________ ☐

Fax: __________________________ ☐

Birth Place: ___________________________

Birth Date: ____________________________

Gender: ☐ Male ☐ Female

I, the undersigned, attest that the information provided herein is true to the best of my knowledge:

______________________________________________
Signature of applicant Date

**Citizenship:**

☐ US Citizen ☐ Permanent Resident ☐ Refugee/asylum/displaced

☐ Foreign National ☐ Conditional Permanent Resident

**Current and Expected Visa Types** *(for Non-U.S. Nationals only - select all that may apply)***:**

☐ **B-1** - Temporary visitor for business

☐ **B-2** - Temporary visitor for pleasure

☐ **F-1** - Academic student

☐ **F-2** - Spouse or child of F-1

☐ **H-1** - Temporary worker

☐ **H-1B** - Specialty occupation, DoD worker, etc.

☐ **H-2B** - Temporary worker - skilled and unskilled

☐ **H-4** - Spouse or child of H-1, H-2, H-3

☐ **J-1** - Visa for exchange visitor

☐ **J-2** - Spouse or child of J-1

☐ **O-1** - Extraordinary ability in sciences, arts, education, business, or athletics

☐ **TN** - NAFTA trade visa for Canadians and Mexicans

☐ **E-2** – Treaty investor, spouse and children

☐ **Diplomatic Service**

☐ **Immigrant**

☐ **EAD** – Employment Authorization

☐ **Other** (describe): ______________________________________________

**USMLE ID**: ______________________________(Required for USMLE transcript transmission)

**NBOME ID**: ____________________________(Required for COMLEX transcript transmission)

**International Medical Graduates only:**

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

☐ Yes ☐ No

Date of ECFMG certification: Month ___________ Year _____

### Service Obligations

Are you committed to fulfill U.S. military active duty service obligations/deferments?

☐ Yes ☐ No

If yes, date of anticipated fulfillment of obligation: _________________

Military branch: _________________

Do you have any other service obligations? (i.e., Military Reserves or Public Health/State programs)

☐ Yes ☐ No

Description:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

### Education (include only higher education)

For each higher education institution you have attended, please provide the requested information. Describe further entries in the space provided at the end of this application.

**Entry 1:**

Institution: ____________________________________________________________________________

Location: ______________________________________________________________________________

Education Type: ☐ Undergraduate ☐ Graduate ☐ Other

Major: ________________________________________________________________________________

Degree expected or earned: ☐ Yes ☐ No

Degree: __________________________________ Degree Month: ____________ Degree Year: ________

Dates of Attendance: From: Month ___________ Year _____ To: Month ___________ Year _____
*Leave To: month/year blank if experience is ongoing.*

**Entry 2** *(leave blank if not applicable)***:**

Institution: ___________________________________________________________________

Location: _____________________________________________________________________

Education Type: ☐ Undergraduate ☐ Graduate ☐ Other

Major: ________________________________________________________________________

Degree expected or earned: ☐ Yes ☐ No

Degree: ______________________________ Degree Month: ___________ Degree Year: _______

Dates of Attendance: From: Month __________ Year _____ To: Month __________ Year _____
*Leave To: month/year blank if experience is ongoing.*

### Medical Education

For each medical school you have attended, please provide the requested information. Describe further entries in the space provided at the end of this application.

**Entry 1:**

Country: ________________ Institution: _____________________________________________

Degree expected or earned: ☐ Yes ☐ No

Degree: ______________________________ Degree Month: ___________ Degree Year: _______

Dates of Attendance:

From: Month __________ Year _____ To: Month __________ Year _____
*Leave To: month/year blank if experience is ongoing.*

**Entry 2** *(leave blank if not applicable)***:**

Country: ________________ Institution: _____________________________________________

Degree expected or earned: ☐ Yes ☐ No

Degree: ______________________________ Degree Month: ___________ Degree Year: _______

Dates of Attendance:

From: Month __________ Year _____ To: Month __________ Year _____
*Leave To: month/year blank if experience is ongoing.*

## Current/Prior Training

For each internship, residency, or fellowship training position you have had or currently hold, regardless of the amount of time spent at each, please provide the requested information. Describe further entries in the space provided at the end of this application.

**Entry 1:**

Type of Training: ☐ Internship ☐ Residency ☐ Fellowship

Specialty: _________________ Institution/Program: _________________________________________

Country: _________________ State/Province: _________________ City: ________________________

From: Month _________________ Year __________To: Month _________________ Year __________

Reason for leaving: ☐ Completed training ☐ Other (please explain):

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Entry 2** *(leave blank if not applicable)***:**

Type of Training: ☐ Internship ☐ Residency ☐ Fellowship

Specialty: _________________ Institution/Program: _________________________________________

Country: _________________ State/Province: _________________ City: ________________________

From: Month _________________ Year __________To: Month _________________ Year __________

Reason for leaving: ☐ Completed training ☐ Other (please explain):

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Entry 3** *(leave blank if not applicable)***:**

Type of Training: ☐ Internship ☐ Residency ☐ Fellowship

Specialty: _________________ Institution/Program: _________________________________________

Country: _________________ State/Province: _________________ City: ________________________

From: Month _________________ Year __________To: Month _________________ Year __________

Reason for leaving: ☐ Completed training ☐ Other (please explain):

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

## Examinations

E.g. USMLE Step 1, 2, 3, in-training exam, NBME Part 1, 2, etc. Describe further entries not included here in the space provided at the end of this application.

☐ **None**

**Entry 1:**

Exam: ___________________________________

Month _________________ Year __________

Score: ______________ ☐ Pass ☐ Fail ☐ N/A

**Entry 2:**

Exam: ___________________________________

Month _________________ Year __________

Score: ______________ ☐ Pass ☐ Fail ☐ N/A

**Entry 3:**

Exam: ___________________________________

Month _________________ Year __________

Score: ______________ ☐ Pass ☐ Fail ☐ N/A

**Entry 4:**

Exam: ___________________________________

Month _________________ Year __________

Score: ______________ ☐ Pass ☐ Fail ☐ N/A

## Licensure/Certification

For each license you currently hold, please provide the requested information. Describe further entries in the space provided at the end of this application.

☐ **None**

**Entry 1:**

State: _________________License Type: ☐ Full ☐ Temporary ☐ Limited ☐ Inactive

License Number: _______________________________________________________

Expiration: Month _________________ Year __________

**Entry 2** *(leave blank if not applicable)***:**

State: _________________License Type: ☐ Full ☐ Temporary ☐ Limited ☐ Inactive

License Number: _______________________________________________________

Expiration: Month _________________ Year __________

**DEA Registration Number** *(if applicable)***:** ___________________________________
*(U.S. medical license holders only)*

Expiration: Month _________________ Year __________

Are you Board Certified? ☐ Yes ☐ No

Certifying board(s): ______________________________________________________________________
*(e.g. American Board of Anesthesiology, American Board of Pediatrics, etc.)*

**Life Support Certification:**

☐ ACLS (Advanced Cardiac Life Support) certified in the U.S.A. Expiration Date: ________________

☐ PALS (Pediatric Advanced Life Support) certified in the U.S.A. Expiration Date: ________________

**Miscellaneous**

Has your medical license ever been suspended/revoked/voluntarily terminated?

☐ Yes ☐ No

Reason:

Have you ever been named in a malpractice case?

☐ Yes ☐ No

Reason:

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?

☐ Yes ☐ No

Reason:

Have you ever been convicted of a felony?

☐ Yes ☐ No

Reason:

Was your medical education/training extended or interrupted?

☐ Yes ☐ No

Please explain, in detail, any gaps in your education, training, or employment following your attainment of a medical degree:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If you were ever off-cycle in your training, please explain why:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If you have been employed since leaving your training, please list each position you have held, including nature of practice, types of cases, dates employed, and reason(s) for leaving:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Are you able to carry out the responsibilities of a regional anesthesia fellow at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements, including overnight work, without accommodations?

☐ Yes

☐ No *(please explain any accommodations required)*:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please use the attached “Additional Information” page to provide any information not included above.

Please provide a personal statement, which should include, but not be limited to, the following:

Briefly describe your interest in regional anesthesiology and acute pain medicine.

What are your career goals *(academic, private practice, patient mix, etc.)*?

What interests do you have outside of medicine?

Additional Information: