Application for Advanced Second Year Fellowship in Pediatric Anesthesiology

Please check the fellowship program you are applying for:

☐ Cardiac ☐ Education ☐ Pain ☐ Research ☐ Quality and Outcomes

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

Optional: Please affix a recent passport-sized photo of yourself here

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 pediatric 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 the advanced second year fellowship training field you have chosen.

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

What interests do you have outside of medicine?

Additional Information: