|  |  |  |
| --- | --- | --- |
|  | APPLICATION FOR  FELLOWSHIP | |
| **INSTRUCTIONS:** | | |
| Type or print legibly in ink. Each part should be answered completely  and accurately. If a question is not applicable, enter “N/A”.  An incomplete application may delay action or disqualify you.  **Please do not enter "seeCV**".  These are the required documents to complete your application:   * Application form * Current Curriculum Vitae * Letter of intent/personal statement * One reference letter from residency program director or current director, and two other current references * Copy of medical school diploma * Copy of residency diploma * Current medical license (U.S. or other) * Documentation of all three steps of USMLE * ECFMG certificate (if applicable) | | Scanned **electronic** applications via email in **.pdf**, **.jpg**. or **.docx** format are the preferred submission mode, but faxed or mailed material will be accepted. For application purposes emailed references are acceptable. Signed originals must be provided on acceptance into the program.   |  | | --- | | This application should be emailed to: **shana.emery@seattlechildrens.org** |   or it may be faxed to: 206-987-3935  Applications will also be accepted by mail at:  Shana Emery  Seattle Children's Hospital Department of Anesthesiology & Pain Medicine  Box 359300, MB.11.500  Seattle, WA 98195-6540 |

Section A

|  |  |  |  |
| --- | --- | --- | --- |
| FELLOWSHIP APPLYING FOR: (Please choose only ONE fellowship) | | | |
|  | Neuroanesthesiology |  | Critical Care Anesthesiology |
|  | Obstetric Anesthesiology |  | Cardiothoracic Anesthesiology |
|  | Pre-Anesthesia and Pre-Operative Evaluation |  | Pediatric Regional Anesthesiology |
|  | Trauma Anesthesiology |  | Pediatric Pain Medicine |
|  | Adult Regional Anesthesiology |  | Pediatric Cardiac Anesthesia |
|  | Global Health and Anesthesiology |  |  |

Section B

|  |  |  |  |
| --- | --- | --- | --- |
| DURATION OF FELLOWSHIP APPLYING FOR: (please choose ONE option) | | | |
|  | One-year fellowship |  | Two-year fellowship |

Section 1

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL INFORMATION** | | | | | | | | | | |
| Family Name (surname) | | | First Name | | | | Middle Initial | |  | |
|  | | |  | | | |  | |  | |
| Mailing Address | | | | | | | | | | |
|  | | | | | | | | | | |
| Email Address | | Cell Phone | | Fax | | | | Other Phone | | |
|  | |  | |  | | | |  | | |
| Are you a U.S. citizen? | Are you a Permanent U.S. Resident? | | | | | If not a U.S. citizen, type of Visa | | | | Visa number |
| YES  NO |  | | | | |  | | | |  |
| If a graduate of foreign medical school, are you ECFMG certified? | | | | | ECFMG number | | | | | |
| YES  NO | | | | |  | | | | | |

Section 2

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MEDICAL LICENSURE | | | | |
| Are you licensed to practice medicine? | In which states or countries? | Washington state license number: | DEA number: | NPI Number: |
| YES  NO |  |  |  |  |

Section 3

|  |  |
| --- | --- |
| BOARD CERTIFICATION | |
| Anesthesiology | Other Specialty |
| ACLS: YES  NO  Expiration Date: |  |

Section 4

|  |  |  |
| --- | --- | --- |
| USMLE TEST SCORES | | |
| Step 1 | Step 2 | Step 3 |
|  |  |  |

Section 5

|  |  |  |
| --- | --- | --- |
| REFERENCES  A minimum of **three** letters of recommendation are required, **including** one from the residency program director **or** current director, and two other individuals with whom the applicant **worked closely in the last two years**. The letters need to bear a current date and the signature of the writer on the official letterhead of their institution. Emailed references are acceptable; originals will be requested upon acceptance into the program. | | |
| Name | Title | Institution, City, State, Country |
|  | *Program Director* |  |
|  |  |  |
|  |  |  |

Section 6

|  |  |  |  |
| --- | --- | --- | --- |
| INTERNSHIP, RESIDENCY AND FELLOWSHIP | | | |
| Medical Center & Location | Specialty | Started  (Month/ Day/Year) | Completed  (Month/ Day/Year) |
|  |  |  |  |
|  |  |  |  |

Section 7

|  |  |  |  |
| --- | --- | --- | --- |
| PhD | | | |
| School & Location | Major Area of Study | Degree | Date Awarded  (Month/ Day/Year) |
|  |  |  |  |

Section 8

|  |  |  |
| --- | --- | --- |
| MEDICAL EDUCATION | | |
| Medical Center & Location | Degree | Completed  (Month/ Day/Year) |
|  |  |  |

Section 9

|  |  |  |  |
| --- | --- | --- | --- |
| PRE-MEDICAL EDUCATION | | | |
| School & Location | Major Area of Study | Degree | Date Awarded  (Month/ Day/Year) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Section 10

|  |
| --- |
| MEMBERSHIP IN PROFESSIONAL SOCIETIES |
|  |

Section 11

|  |
| --- |
| HONORS, SCHOLARSHIPS, GRANTS, ETC. |
|  |

Section 12

|  |
| --- |
| PUBLICATIONS AND RESEARCH  List any significant publications (including publisher and date of publication) and any major research projects undertaken |
|  |

Section 13

|  |  |  |
| --- | --- | --- |
| APPLICANT DISCLOSURES | | |
| “Yes” answers to the following questions require written explanation on a separate sheet. Positive responses to questions do not necessarily preclude acceptance. | | |
|  | Yes | No |
| Have you ever been involved in a malpractice lawsuit or claim  (whether or not you were individually named as a defendant)? |  |  |
| Have you ever been called before any entity for questioning concerning unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment |  |  |
| If you have been licensed to practice medicine, has any such license ever been  denied, revoked, suspended or restricted? |  |  |
| Have you ever been addicted to, or treated for addiction to a controlled  substance, drug or chemical? |  |  |
| Have you ever used a prescription drug, including controlled substances, for  other than therapeutic purposes? |  |  |
| Are you currently suffering from any disability or illness (mental or Physical)  which could affect your ability to fully practice medicine? |  |  |

Section 14

|  |  |
| --- | --- |
| HOW DID YOU HEAR ABOUT US? | |
| In order to assess the program recruitment efficacy we would like to know how you heard about the Faculty Fellowship Program at the University of Washington Department of Anesthesiology & Pain Medicine. Your answers are voluntary and lack thereof will not result in your application being deemed incomplete. Please fill in your answers below, thank you. | |
| Internet search engine, indicate which |  |
| Professional website, which |  |
| Academic Adviser, which institution |  |
| Word of mouth, please explain |  |
| Other, please explain |  |
| # of fellowships applied for to date |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |