UW Medicine
ANESTHESIOLOGY & PAIN MEDICINE

APPLICATION FOR FACULTY 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 "see CV".

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:
sarahkb@uw.edu

Applications will also be accepted by mail at:

Sarah Barstad
University of Washington School of Medicine
Montlake Campus
1959 NE Pacific Street
Box 356540
Seattle, WA 98195

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	○	Perioperative Quality and Patient Safety
○	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 authorized to work in the U.S.? YES ☐ NO ☐			
If a graduate of foreign medical school, are you ECFMG certified? YES ☐ NO ☐	ECFMG number		

Section 2

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

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 _____