Common Application for Fellowship in Regional Anesthesiology and Acute Pain Medicine

Applying for academic year: 20___/20___

Personal Information

First Name	Middle Name	Last Name
Previous Last Name	Preferred Name	Contact email
NRMP ID	AAMC ID	Contact Phone

Present Mailing Address:

Street Address	Apt #	City
State/Province	Zip Code	Country

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

Street Address	Apt #	City
State/Province	Zip Code	Country
Phone number	email	

Are you a U.S. Citizen?	Visa Status (if applicable):	Are you certified by the ECFMG?
◯Yes ◯No	◯Permanent ◯J-1 ◯H-1B ◯Other:_____ Expiration date: _____	◯Yes ◯No Date of Certification: ___/___ ECFMG Number:_____

I certify that the information in this application is true and complete to the best of my knowledge and that I have not withheld information that might significantly affect my qualifications for fellowship training. I authorize any training program that receives this application to contact any or all of my former employers, educational institutions and/or other persons or organizations that may have information relevant to my application.

I understand that any information obtained will be treated as confidential.

_____

Signature of applicant Date

Note: It is a violation of federal and state anti-discrimination law to discriminate against applicants because of an individual's race, color, religion, age, gender, sexual orientation, national origin, genetic information, veteran status, or disability.

Name_____

A. EDUCATION

Non-Medical Education-list chronologically (include only higher education)

School 1

Institution | Education Type: ○ Undergraduate ○ Graduate ○ Other

City | State | Degree Awarded | Dates Attended *(mo/yr to mo/yr)*

School 2

Institution | Education Type: ○ Undergraduate ○ Graduate ○ Other

City | State | Degree Awarded | Dates Attended *(mo/yr to mo/yr)*

School 3

Institution | Education Type: ○ Undergraduate ○ Graduate ○ Other

City | State | Degree Awarded | Dates Attended *(mo/yr to mo/yr)*

School 4

Institution | Education Type: ○ Undergraduate ○ Graduate ○ Other

City | State | Degree Awarded | Dates Attended *(mo/yr to mo/yr)*

Medical Education

School 1

Institution | Country

City | State | Degree Awarded | Dates Attended *(mo/yr to mo/yr)*

School 2

Institution | Country

City | State | Degree Awarded | Dates Attended *(mo/yr to mo/yr)*

List any honors or awards obtained during your education (e.g. AOA obtained in medical school):

Was your education ever interrupted or extended? ○ Yes ○ No
If yes, please explain:

Name_____

B. TRAINING

Current / Prior Medical Training

List each internship, residency, or fellowship training position you have had or currently hold, regardless of the amount of time spent at each.

Training 1

Institution | Education Type: ○ Internship ○ Residency ○ Fellowship | Program Director

Program | City | State

Dates of Attendance *(mo/yr to mo/yr)* | Status: ○ Completed ○ In progress ○ Other (please explain)

Training 2

Institution | Education Type: ○ Internship ○ Residency ○ Fellowship | Program Director

Program | City | State

Dates of Attendance *(mo/yr to mo/yr)* | Status: ○ Completed ○ In progress ○ Other (please explain)

Training 3

Institution | Education Type: ○ Internship ○ Residency ○ Fellowship | Program Director

Program | City | State

Dates of Attendance *(mo/yr to mo/yr)* | Status: ○ Completed ○ In progress ○ Other (please explain)

Training 4

Institution | Education Type: ○ Internship ○ Residency ○ Fellowship | Program Director

Program | City | State

Dates of Attendance *(mo/yr to mo/yr)* | Status: ○ Completed ○ In progress ○ Other (please explain)

Have you ever been discharged/terminated/failed to have a contract renewed by a training program? ○ Yes ○ No

Have you ever resigned from or been placed on probation by a training program? ○ Yes ○ No

Was your medical training ever interrupted or extended? ○ Yes ○ No

Please explain any "Yes" answers to the above, including any gaps in training:

Name_____

C. EMPLOYMENT/RESEARCH

Work Experience
Please include relevant work, research, volunteer, teaching, or committee work.

	Organization	Title/Position	Dates (mo/yr to mo/yr)
Job 1			
	Brief Job Description	City	State
	Organization	Title/Position	Dates (mo/yr to mo/yr)
Job 2			
	Brief Job Description	City	State
	Organization	Title/Position	Dates (mo/yr to mo/yr)
Job 3			
	Brief Job Description	City	State
	Organization	Title/Position	Dates (mo/yr to mo/yr)
Job 4			
	Brief Job Description	City	State

Research:
Please detail research experience, publications, or grants.

Name_____

D. RESULTS

Examinations:
Fully complete the following table, including percentile ranking where appropriate. Circle an entry to indicate which exam was taken when more than one exam is listed on a line.

USMLE 1/ COMLEX 1	Month/Year	Number of times taken	Score (2 digit / 3 digit) /
USMLE 2 CK / COMLEX 2 CE	Month/Year	Number of times taken	Score (2 digit / 3 digit) /
USMLE 2 CS / COMLEX 2 PE	Month/Year	Number of times taken	Score ☐ Passed ☐ Failed
USMLE 3 / COMLEX 3	Month/Year	Number of times taken	Score (2 digit / 3 digit) /
ABA PGY1 In-Training Exam	Month/Year	Status ☐ Taken ☐ Not taken	Score (raw / percentile) /
ABA CA-1 In-Training Exam	Month/Year	Status ☐ Taken ☐ Not taken	Score (raw / percentile) /
ABA Basic Exam	Month/Year	Status ☐ Passed # of attempts ____ ☐ Failed ☐ Will take	
ABA CA-2 In-Training Exam	Month/Year	Status ☐ Taken ☐ Not taken ☐ Awaiting results ☐ Will take	Score (raw / percentile) /
ABA CA-3 In-Training Exam	Month/Year	Status ☐ Taken ☐ Not taken ☐ Awaiting results ☐ Will take	Score (raw / percentile) /
Exam other	Month/Year	Status ☐ Passed ☐ Awaiting results ☐ Failed ☐ Will take	Score
Exam other	Month/Year	Status ☐ Passed ☐ Awaiting results ☐ Failed ☐ Will take	Score

Licensure/Certification

For each license you hold (or previously held), please provide the requested information. Describe further entries in the space provided in the next section.

State	License Type	License Number	Expiration (mo/yr)
	☐ Full ☐ Temporary or Limited ☐ Training ☐ Inactive		
State	License Type	License Number	Expiration (mo/yr)
	☐ Full ☐ Temporary or Limited ☐ Training ☐ Inactive		

☐ I do not hold a medical license

Are you Board Certified? ○ Yes ○ No
Certifying Board(s): _____ Expiration Date(s): _____
(e.g. American Board of Anesthesiology, American Board of Internal Medicine, etc.)

Name_____

E. DECLARATIONS AND ATTESTATIONS

Has your medical license ever been suspended/revoked/voluntarily terminated? ○ Yes ○ No

Have you ever been named in a malpractice case? ○ Yes ○ No

[redacted]

Is there anything that would limit your ability to be licensed or receive hospital privileges? ○ Yes ○ No

Are you committed to fulfill U.S. military duty service obligations/deferments? ○ Yes ○ No

If yes, date of anticipated fulfillment of obligation (month/day/year): _____ to _____

Military Branch: _____

Do you have any other service obligations (i.e., Public Health/State Programs)? ○ Yes ○ No

Description: _____

Please use the space provided below to explain any "yes" answers from above. You may attach additional sheets as necessary. You may also include here any additional details from previous sections that are relevant to your application.

Name_____

F. REFERENCES

Three letters of reference are required. **One letter from your training program director is required**. The other two letters should be from objective physicians (i.e, not relatives or family friends) who have direct personal knowledge of your skills and ethics. Please indicate below the letters of reference that are part of your application.

Letter of Reference #1 (Training Program Director)

Name and Title:

Institution:

Email address: | Phone:

- ○ I have waived access to this letter and have informed the author of this confidentiality.
- ○ I desire access to the above letter and have informed the author.

Letter of Reference #2

Name and Title:

Institution:

Email address: | Phone:

- ○ I have waived access to this letter and have informed the author of this confidentiality.
- ○ I desire access to the above letter and have informed the author.

Letter of Reference #3

Name and Title:

Institution:

Email address: | Phone:

- ○ I have waived access to this letter and have informed the author of this confidentiality.
- ○ I desire access to the above letter and have informed the author.

Name_____

G. ADDITIONAL INFORMATION

Personal Statement

What particular personal qualifications and characteristics will allow you to become an effective consultant in regional anesthesiology and acute pain medicine, and why is it important to you to become a regional anesthesiologist? Use only the space provided.

Name_____

Extended Questions.

Please choose **two** of the following questions and answer each one in the space provided (suggested length no longer than 200 words per question).

a. How will completion of a regional anesthesiology and acute pain medicine fellowship allow you to further your goals?

b. Describe what you consider to be your most significant contribution or achievement, including the impact you made.

c. Being a part of hospital leadership should be important to anesthesiologists. What role do you think you might take within the leadership structure of your future hospital?

d. Describe a challenging situation in your life or career and what you learned from it.

Question #1 Choose a, b, c, or d from dropdown

Question #2 Choose a, b, c, or d from dropdown

Voluntary Affirmative Action (EEO) Form

University of Nebraska Medical Center is an Equal Employment Opportunity Employer. We do not discriminate on the basis of race, religion, color, gender, sexual orientation, pregnancy, national origin, ancestry, ethnicity, age, disability, military or veteran status or any other classification protected by law in hiring, promotion, compensation and other terms and conditions of employment. The information on this form will not be used in any employment decision. As a federal contractor, the United States government requires University of Nebraska Medical Center to collect and maintain information regarding gender, race and ethnicity for affirmative action purposes. University of Nebraska Medical Center is also subject to various governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. The information on this form will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual. Completion of this form is voluntary and refusal to provide information will not subject you to any adverse treatment.

Completion of this form is *voluntary*.

PART I.

Last Name			
First Name		**Middle Initial**	
Last 4 Digits of Your Social Security Number (Optional)			
Gender	☐ Male ☐ Female		
Military Status (Check if applicable)	☐ Disabled Veteran ☐ Recently Separated Veteran ____/____/____ (Date of Discharge) ☐ Other Protected Veteran ☐ Armed Forces Service Medal Veteran		

PART II.

SELF-IDENTIFICATION OF RACE AND ETHNICITY

1. Are you Hispanic or Latino? ☐ Yes ☐ No

Hispanic or Latino means a person of Cuban, Mexican, Puerto Rican, Central American, South American or other Spanish culture or origin regardless of race.

2. If you answered "No" to Question 1, what is your racial identification?

☐ **White** – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
☐ **Black or African American** – A person having origins in any of the black racial groups of Africa.
☐ **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐ **Two or more races**

Today's Date:_____