UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
DEPARTMENT OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

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ANESTHESIOLOGY CRITICAL CARE MEDICINE FELLOWSHIP APPLICATION

Program: Anesthesiology Critical Care Medicine PGY Level: 5

Training to begin: _____ Number of years of training sought: 1

PERSONAL DATA:

Full Name: _____

Address: _____ Day Telephone: _____

_____ Night Telephone: _____

_____

Email Address: _____

In case of emergency, notify: _____ Relationship: _____

EDUCATION:

	School Name and Location	Major Field	Degree	Dates
Undergraduate				
Graduate				
Medical School				

RESIDENCY TRAINING:

Hospital Name and Location	Program	Dates

Please indicate any other professional activities (practice, research, military, training) since graduation from medical school:

Activity	Location	Dates

CURRENT LICENSURE:

State	License Number	Date Issued	Date Expired

EXAMINATIONS:

USMLE Step 1: _____ COMLEX Step 1: _____

USMLE Step 2 CK: _____ COMLEX Step 2: _____

USMLE Step 2 CS: _____ COMLEX Step 2 PE: _____

USMLE Step 3: _____ COMLEX Step 3: _____

Anesthesia ITE CA0: _____ Anesthesia ITE CA1: _____

Anesthesia ITE CA2: _____ Anesthesia ITE CA3: _____

BOARD CERTIFICATIONS:

Eligible in: _____

_____

Certified in: _____ Date: _____

_____ Date: _____

ECFMG STATUS:

ECFMG number: _____

Valid until: _____

Date Issued: _____

VISA STATUS – If you are not a citizen of the U.S., please provide the following information:

Current Non-Immigrant (Temporary) Visa Type: _____ Sponsor: _____

Or

Current Immigrant (Permanent) Status: _____

Expected Visa or Immigration Status at the time of Appointment: _____

NATIONAL MATCH PROGRAM:

Have you signed an agreement with the National Resident Matching Program or SF Match (circle one): YES / NO

INTERVIEW AVAILABILITY (if invited for an interview, when are you available?): _____

_____

ADDITIONAL INFORMATION:

Please attach a copy of your Curriculum Vitae and a personal statement describing your reason for pursuing a critical care fellowship and your future career goals.

Attach a recent 3" x 3" photograph (optional)

REFERENCES: Please identify three faculty members/attending physicians who are familiar with your clinical performance and request letters of reference be sent via email to the program director and program coordinator.

Name and Title	Email Address
1.	
2.	
3.	

DATE OF APPLICATION: _____

SIGNATURE: _____

Please return this application to the UMass ACCM Fellowship Program Director and Program Coordinator. Upon review, the program may request additional information, including a Dean's Letter/MSPE, score reports, or additional references.

Please note: The University of Massachusetts Medical Center is an Affirmative Action/Equal Opportunity Employer and is committed to increasing minority representation among its Residents and Fellows. If you wish to do so, please list your minority status: _____