UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL
Department of Anesthesiology
55 Lake Avenue North
Worcester, Massachusetts 01655
(508) 856-3821; EMail lisa.nicholson@umassmed.edu

APPLICATION FOR A FELLOWSHIP IN ANESTHESIOLOGY CRITICAL CARE MEDICINE

Program in: ______________________ PGY Level: __________ __________

Training to begin: ______________ Number of years of training sought: ______________

PERSONAL DATA:

Name in full: ______________ (First) ______________ (Middle) ______________ (Last)

Present address: ______________________ (Street) Day Tel: ( ) ______________

______________________ (City) (State) (Zip) Night Tel: ( ) ______________

Permanent address: ______________________ (Street) Tel: ( ) ______________

______________________ (City) (State) (Zip)

Social Security Number: ______________

In case of emergency, notify: ______________ Relationship: ______________

Address: ______________________ Tel: ( ) ______________

EDUCATION: List all schools and inclusive dates attended.

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

RESIDENCY TRAINING:

Hospital Name and Location		Program	Dates

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

Activity	Location	Dates

CURRENT LICENSURE:

State	Type	Number	Date Issued	Date Expired
___	___	___	___	___
___	___	___	___	___

EXAMINATIONS:

National Board of Medical Examiners (NBME)

	Date Taken	Score
Part I	___	___
Part II	___	___
Part III	___	___

Federation of State Medical Boards (FLEX)

	Date Taken	Score
Component I	___	___
Component II	___	___

United States Medical Licensing Examination (USMLE)

	Date Taken	Score
Step 1	___	___
Step 2	___	___
Step 3	___	___

Foreign Medical Graduate Examination in Medical Sciences (FMGEMS)

	Date Taken	Score
Day 1 (Basic Science)	___	___
Day 2 (Clinical Science)	___	___

American Specialty Boards

Eligible in: ___

Certified in: ___ 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? _______ Number: ____________________

INTERVIEW: When are you available for an interview?

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ADDITIONAL INFORMATION: (Please list honors, research projects, special interests, publications, teaching appointments and relevant work experiences; or attach a copy of your curriculum vitae or resume and a personal statement.):

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TRAINING PLANS (What type and how many years of training do you anticipate):

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CAREER GOALS (What are your career plans and preferences):

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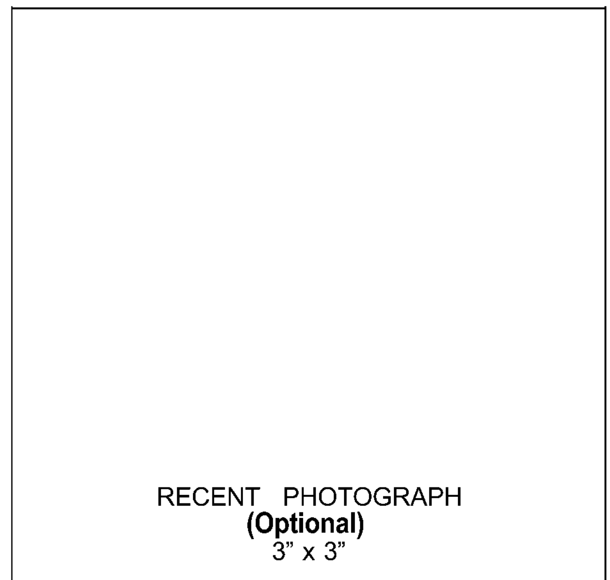
REFERENCES: List three faculty members of your medical school or attending physicians who are familiar with your clinical performance and request that letters of reference be sent directly to the UMMC Program Director.

	First - Last Name & Title	Address
1.		
2.		
3.		

Date of application: ______________________________

SIGNATURE: ______________________________



The application may be submitted via mail to:
Anesthesiology Critical Care Medicine Fellowship
Department of Anesthesiology
UMass Memorial Medical Center
55 Lake Avenue North
Worcester, MA 01655
via FAX to 508-856-5911,
or via EMail to lisa.nicholson@umassmed.edu

Please request the Dean of your medical school to send a copy of your Dean's letter and your medical school transcript.

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: ______________________________