

## Common Application for Fellowship in Obstetric Anesthesiology

Applying for academic year: 20\_\_/20\_\_

<b>Personal Information</b>		
First Name	Middle Name	Last Name
Previous Last Name	Preferred Name	Contact email
NRMP ID	AAMC ID	Contact Phone
<b>Present Mailing Address:</b>		
Street Address	Apt #	City
State/Province	Zip Code	Country
<b>Future Mailing Address (if applicable):</b>		<i>Beginning date:</i>
Street Address	Apt #	City
State/Province	Zip Code	Country
Phone number	email	

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

**A. EDUCATION****Non-Medical Education-list chronologically (include only higher education)**

<b>School 1</b>	Institution			Education Type		
				<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other		
	City	State	Degree Awarded	Dates Attended (mo/yr to mo/yr)		
<b>School 2</b>	Institution			Education Type		
				<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other		
	City	State	Degree Awarded	Dates Attended (mo/yr to mo/yr)		
<b>School 3</b>	Institution			Education Type		
				<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other		
	City	State	Degree Awarded	Dates Attended (mo/yr to mo/yr)		
<b>School 4</b>	Institution			Education Type		
				<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other		
	City	State	Degree Awarded	Dates Attended (mo/yr to mo/yr)		

**Medical Education**

<b>School 1</b>	Institution			Country
	City	State	Degree Awarded	Dates Attended (mo/yr to mo/yr)
<b>School 2</b>	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:

**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.

<b>Training 1</b>	Institution	Education Type <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship	Program Director
	Program	City	State
	Dates of Attendance ( <i>mo/yr to mo/yr</i> )	Status <input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Other (please explain)	
<b>Training 2</b>	Institution	Education Type <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship	Program Director
	Program	City	State
	Dates of Attendance ( <i>mo/yr to mo/yr</i> )	Status <input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Other (please explain)	
<b>Training 3</b>	Institution	Education Type <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship	Program Director
	Program	City	State
	Dates of Attendance ( <i>mo/yr to mo/yr</i> )	Status <input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Other (please explain)	
<b>Training 4</b>	Institution	Education Type <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship	Program Director
	Program	City	State
	Dates of Attendance ( <i>mo/yr to mo/yr</i> )	Status <input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> 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:

**C. EMPLOYMENT/RESEARCH****Work Experience**

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

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

**Research:**

Please detail research experience, publications, or grants.

**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 <input type="checkbox"/> Passed <input type="checkbox"/> Failed
USMLE 3 / COMLEX 3	Month/Year	Number of times taken	Score (2 digit / 3 digit) /
ABA PGY1 In-Training Exam	Month/Year	Status <input type="checkbox"/> Taken <input type="checkbox"/> Not taken	Score (raw / percentile) /
ABA CA-1 In-Training Exam	Month/Year	Status <input type="checkbox"/> Taken <input type="checkbox"/> Not taken	Score (raw / percentile) /
ABA Basic Exam	Month/Year	Status <input type="checkbox"/> Passed # of attempts ____ <input type="checkbox"/> Failed <input type="checkbox"/> Will take	
ABA CA-2 In-Training Exam	Month/Year	Status <input type="checkbox"/> Taken <input type="checkbox"/> Not taken <input type="checkbox"/> Awaiting results <input type="checkbox"/> Will take	Score (raw / percentile) /
ABA CA-3 In-Training Exam	Month/Year	Status <input type="checkbox"/> Taken <input type="checkbox"/> Not taken <input type="checkbox"/> Awaiting results <input type="checkbox"/> Will take	Score (raw / percentile) /
Exam other	Month/Year	Status <input type="checkbox"/> Passed <input type="checkbox"/> Awaiting results <input type="checkbox"/> Failed <input type="checkbox"/> Will take	Score
Exam other	Month/Year	Status <input type="checkbox"/> Passed <input type="checkbox"/> Awaiting results <input type="checkbox"/> Failed <input type="checkbox"/> 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 <input type="checkbox"/> Full <input type="checkbox"/> Temporary or Limited <input type="checkbox"/> Training <input type="checkbox"/> Inactive	License Number	Expiration (mo/yr)
State	License Type <input type="checkbox"/> Full <input type="checkbox"/> Temporary or Limited <input type="checkbox"/> Training <input type="checkbox"/> Inactive	License Number	Expiration (mo/yr)

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 Pediatrics, 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

Have you ever been convicted of a misdemeanor, including alcohol-related offenses?  Yes  No

Have you ever been convicted of a felony?  Yes  No

Have you ever been charged with use or possession of illegal drugs?  Yes  No

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 also include here any additional details from previous sections that are relevant to your application.*

**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.

<b>Letter of Reference #1 (Training Program Director)</b>	
Name and Title:	
Institution:	
Email address:	Phone:
<input type="checkbox"/> I have waived access to this letter and have informed the author of this confidentiality. <input type="checkbox"/> I desire access to the above letter and have informed the author.	
<b>Letter of Reference #2</b>	
Name and Title:	
Institution:	
Email address:	Phone:
<input type="checkbox"/> I have waived access to this letter and have informed the author of this confidentiality. <input type="checkbox"/> I desire access to the above letter and have informed the author.	
<b>Letter of Reference #3</b>	
Name and Title:	
Institution:	
Email address:	Phone:
<input type="checkbox"/> I have waived access to this letter and have informed the author of this confidentiality. <input type="checkbox"/> 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 obstetric anesthesiology, and why is it important to you to become an obstetric anesthesiologist? Use only the space provided.