Fellowship Application Form

Anesthesiology Pain Medicine

SCHOOL OF MEDICINE • SAN ANTONIO
UT HEALTH SCIENCE CENTER®
DEPARTMENT OF ANESTHESIOLOGY

Section I: Personal Profile

Anesthesia Pain Medicine Fellowship to begin on:			Gender:
Name:			☐ MD ☐ DO
Home Street Address:			
City:		State:	Zip:
Phone Number: (_____)	Pager Number: (_____)	Cell Phone Number: (_____)	
Email Address:		Fax: (_____)	

Work Address:		
City:	State	Zip:
Phone Number: (_____)	Fax Number: (_____)	

Date of Birth:	Place of Birth:
Social Security # if US Citizen:	Citizenship:
If Alien, date of entry:	ECFMG # (enclose copy of ECFMG certificate if applicable):
Visa Status (if not a US citizen):	Visa Number:

Section II: Education

College and Post-Graduate Education (list all schools attended)	
Name of University:	
Location:	
Education type: ☐ Undergraduate ☐ Graduate ☐ Other	Major:
Degree earned and date degree conferred:	
Dates of attendance:	
Reason for departure if degree program not completed:	

College and Post-Graduate Education (continued)	
Name of University:	
Location:	
Education type: ☐ Undergraduate ☐ Graduate ☐ Other	Major:
Degree earned and date degree conferred:	
Dates of attendance:	
Reason for departure if degree program not completed:	

Name of University:	
Location:	
Education type: ☐ Undergraduate ☐ Graduate ☐ Other	Major:
Degree earned and date degree conferred:	
Dates of attendance:	
Reason for departure if degree program not completed:	

Medical School (list all schools attended)	
Name of University:	
Location:	
Education type: ☐ MD ☐ DO	Date degree conferred:
Dates of attendance:	
Reason for departure if program not completed:	

Name of University:	
Location:	
Education type: ☐ MD ☐ DO	Date degree conferred:
Dates of attendance:	
Reason for departure if program not completed:	

Internship		
Specialty:		
Name of program or Institution:		
Complete street address:		
City:	State:	Zip:
Program Director:	Contract # (if applicable):	

Residency (list all programs attended)		
Specialty:		
Name of program or Institution:		
Complete street address:		
City:	State:	Zip:
Program Director:	Contract # (if applicable):	
Reason for departure if program not completed:		

Specialty:		
Name of program or Institution:		
Complete street address:		
City:	State:	Zip:
Program Director:	Contract # (if applicable):	
Reason for departure if program not completed:		

Fellowships (list all programs attended)		
Specialty:		
Name of program or Institution:		
Complete street address:		
City:	State:	Zip:
Program Director:	Contract # (if applicable):	
Reason for departure if program not completed:		

Specialty:		
Name of program or Institution:		
Complete street address:		
City:	State:	Zip:
Program Director:	Contract # (if applicable):	
Reason for departure if program not completed:		

Other Education				
Name of University:				
Location:				
Education type:	Undergraduate	Graduate	Other	Major:
Degree earned and date degree conferred:				
Dates of attendance:				
Reason for departure if degree program not completed:				

Gaps in Training and/or Medical Education
If applicable, please provide an explanation of any time gaps in training and/or medical education:

SCHOOL OF MEDICINE • SAN ANTONIO
UT HEALTH SCIENCE CENTER®
DEPARTMENT OF ANESTHESIOLOGY

Section III: Clinical References (Must provide at least three (3) references and one must be your Residency program Director, Department Chair, or your current physician supervisor if you are an independent practitioner).

Clinical References			
Last Name	First Name	Middle Initial, Credentials (MD, DO, Etc.)	
Complete Street Address			
City:		State:	Zip:
Phone Number: (________)		Email Address:	

Clinical References			
Last Name	First Name	Middle Initial, Credentials (MD, DO, Etc.)	
Complete Street Address			
City:		State:	Zip:
Phone Number: (________)		Email Address:	

Clinical References			
Last Name	First Name	Middle Initial, Credentials (MD, DO, Etc.)	
Complete Street Address			
City:		State:	Zip:
Phone Number: (________)		Email Address:	

Section IV: Examination Information

National Board Results			
Exam	**Date of Exam**	**Grade Average/ Percentile**	**# of Attempts**
USLME Step 1			
USLME Step 2			
USLME Step 3			
COMPLEX Step 1			
COMPLEX Step 2			
COMPLEX Step 3			

National Board Identifiers (insert applicable #)	
USMLE ID #	
NBOME ID #	

ANESTHESIOLOGY IN-SERVICE TRAINING (ITE) EXAM RESULTS		
Exam sequence	**Score**	**Percentile**
July CA-1		
July CA-2		
July CA-3		

Section V: Licensure and Certification

List all present and past state medical licensures			
State:	License #:	Date of Issue	Exp Date:
State:	License #:	Date of Issue	Exp Date:
State:	License #:	Date of Issue	Exp Date:
State:	License #:	Date of Issue	Exp Date:

American Specialty Board Certification			
Board:	Certificate #:	Date of Issue/ Recert:	Exp Date (month/ year):
Board:	Certificate #:	Date of Issue/ Recert:	Exp Date (month/ year):

ACLS/ ATLS/ PALS		
ACLS Certified?	ATLS Certified?	PALS Certified?
Exp Date (month/ year):	Exp Date (month/ year):	Exp Date (month/ year):

DEA Registration Number (if applicable)

DEA#:	Expiration Date:

Section VI: Military Service

Prior Military Service		
Branch:	Dates of Service:	Type of discharge:
Brief description of job performed:		
Do you have any additional obligation to the military or federal government? ☐ **No** ☐ **Yes (explain)**		

Section VII: Disclosure Questions

Please provide an explanation for any question answered **YES** on an additional attachment

Education, Training and Board Certification	Yes	No
Have you ever elected to leave any program of training prior to completion?		
Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program?		
If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?		
Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?		
Have any of your board certifications or eligibility ever been revoked?		
Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?		

Licensure	Yes	No
Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?		
Have you ever received a reprimand or been fined by any state licensing board?		

Hospital Privileges and Other Affiliations	Yes	No
Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?		
Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?		
Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?		
Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?		

DEA or DPS	Yes	No
Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?		

Other Sanctions or Investigations	Yes	No
Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?		
Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?		
Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?		

Malpractice Claims History	Yes	No
Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?		

Criminal	Yes	No
Have you ever been convicted of, pled guilty to, or pled nolo contendere to any crime or offense other than a minor traffic violation?		
Do you currently have any misdemeanor or felony charges pending against you?		
Have you been court-martialed while in the military?		

Ability to Perform Job	Yes	No
Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct.)		
Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?		
Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?		
Do you currently have any health related issues that will prevent you from performing the duties and responsibilities of this program of education and/or training with reasonable accommodation?		
Are you otherwise able to carry out the responsibilities of a resident or fellow in the specialties and at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?		

Mental and Physical Health	Yes	No
Within the past five (5) years, have you abused or have you been addicted to alcohol or drugs or have you been treated for alcohol or other substance abuse or dependency?		
Within the past five (5) years, have you been diagnosed with or have you been treated for any of the following: schizophrenia or any other psychotic disorder, delusional disorder, bipolar or manic depressive mood disorder, major depression, personality disorder, or any other mental condition which impaired your behavior, judgment, or ability to function in school, work or other important life activities?		
Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic by the medical community, which impaired or does impair your behavior, judgment, or ability to function in school, work or other important life		

activities?		

Opportunity for explanation of "Yes" Comments. If you need additional space provide an attachment to the application.		

Section VIII: Required Documents and additional instructions

- ☐ **Attach a brief narrative statement discussing your professional objectives**
- ☐ **Attach a copy of your medical school diploma**
- ☐ **Attach a copy of your medical school transcript**
- ☐ **Obtain 3 letters of reference, one of which must be from either you anesthesiology residency Program Director or Program's Department Chairman during your residency and one from you supervisor if you are currently employed as a independent practitioner.**
- ☐ **Attach a photograph (optional)**
- ☐ **Attach a curriculum vitae that should also include the following information:**

Non-Physician Work and Research Experiences
Positions and descriptions
Organizations and locations
Dates of experiences
Non-trainee Physician Experiences
Positions and descriptions
Institutions and address
Dates of experiences
Supervisor's names
Publications

Please mail or e-mail your application materials to the following address. Please *do not* send applications via fax.

Pain Medicine Fellowship Coordinator
Department of Anesthesiology
westkk@uthscsa.edu

7703 Floyd Curl Drive MC 7838
San Antonio TX 78229
Office: 210-567-4506

SCHOOL OF MEDICINE • SAN ANTONIO
UT HEALTH SCIENCE CENTER®
DEPARTMENT OF ANESTHESIOLOGY

Section IX: Certification and Consent for Release of Information

I certify that the information contained within this application is complete and accurate to the best of my knowledge. I authorize the University of Texas Health Science Center to make inquiries to educational institutions, examination boards, state licensing boards, current and/or previous employers, members of the medical staffs and other institutions with which I have been affiliated, regarding education, specific training, experience and current competence in order to aid in my application for a fellowship position within the Department of Anesthesiology. I understand and agree I have the responsibility to produce adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I hereby consent to the release of the above-mentioned information to the officials of the University of Texas Health Science Center I understand that falsification, omission or misrepresentation of any item or response on this application or any supplemental information is a sufficient basis for denying my application, revoking any offered positions, a determination of ineligibility, and/ or nullifying any offered contract(s) given.
Printed Name:

Signature:	Date: