Photo

(passport size)

Regional Anesthesia/Ambulatory Fellowship Application

University of Michigan Health System
Department of Anesthesiology
1H247 UH, SPC 5048
1500 E Medical Center Drive
Ann Arbor, MI 48109-5278

For Office Use Only

Received __________

Reviewed __________

Interviewed __________

Result __________

Note: Please type or print clearly

Fellowship beginning ________, ____ Date of application____/____/____

Name ____
last first middle

Present address____
street city state zip code

Phone (home)________________________(work)______________________(mobile)______________________
include city/country code if applicable

Permanent address____
street city state zip code

Citizenship_______________________________Place of birth____
city/state/country

Social security no._______-_______-________ E-mail ____

Nearest relative____

Address____

Phone day____Evening__________________________________

Name____

EDUCATION

UNDERGRADUATE COLLEGES (other than medical school)

Name Address Degree Month/Year

____

____

GRADUATE SCHOOL (other than medical school)

____

____

MEDICAL SCHOOL

Name Years Attended Degree Month/Year

____

____

INTERNSHIP

PGY 1____

Hospital Address

____

Type From To

RESIDENCY

PGY 2____

Hospital Address

____

Type From To

PGY 3____

Hospital Address

____

Type From To

PGY 4____

Hospital Address

____

Type From To

PGY 5____

Hospital Address

____

Type From To

Name_______________________________________

FELLOWSHIPS: (other)

____
Dates
____
Dates

LICENSED IN THE STATE OF____ Year___________

ECFMG - Number____Year ____________

VQE – Number ____ Year ___________

FMGEMS - Number____Year____________

OTHER: Type of Visa____ Year___________

MILITARY STATUS

Branch: ____Dates___________

Future Obligation: YES NO

Explain: ____

____

____

RESEARCH PROJECTS

Project Place Year

see CV

____

____

____

____

PUBLICATIONS

see CV

____

____

____

____

PRESENTATIONS

see CV

____

____

____

____

Name____

AWARDS AND HONORS

see CV

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____

____

____

PREVIOUS EXPERIENCE (other than in medicine)

____

____

____

____

To complete your application, please arrange for the following to be sent to the address below.

1. Official Medical School Transcript & Diploma
2. Curriculum Vitae
3. Personal Statement (one page)
4. Three Letters of Professional Reference (including one from the Director of your training program)

LIST NAMES AND INSTITUTIONS/ADDRESSES:

1. ____

2. ____

3. ____

____

Applicant Signature **Date**

The application must be completed in its entirety, or it cannot be processed.

Application and all related communications should be addressed to:

Paul Hilliard, MD

University of Michigan Health System

Department of Anesthesiology

1H247 UH, SPC 5048

1500 East Medical Center Drive

Ann Arbor, MI 48109-5278