Wexner Medical Center

# Neuroanesthesia Fellowship Application

Department of Anesthesiology, N 411 Doan Hall
The Ohio State University Medical Center
410 W. 10th Avenue, Columbus, Ohio 43210
attn: Sarah Robertson

Telephone: (614) 293-8487 Fax: (614) 293-1578 Email: anesthesiology@osumc.edu

## General Information

*Name*

*Training period beginning (month, year)*

*Gender*

*Previous last name*

*Birth date*

*Birth place*

*Citizenship(s)/Visa type (if applicable)*

*USMLE ID number*

*Correspondence address*

*Permanent address*

*Primary telephone*

*Alternate telephone*

*Email address*

*Pager*

## ACGME Accredited Pre-Fellowship Residency

*Completed Accredited Anesthesiology Residency*

☐ *Yes*

☐ *No*

## Undergraduate Education

*Undergraduate institution and location*

*Type of degree, field of study, and date of degree*

## Medical Education

*Medical school and location*

*Type of degree and date of degree*

*Medical school awards and membership in honorary professional societies*

- ☐ My medical education was not extended or interrupted.
- ☐ All extensions or interruptions of my medical education are described completely in additional comments.

## Professional examinations

*USMLE Step 1 status and date*

*USMLE Step 2 CK (Clinical Knowledge) status and date*

*USMLE Step 2 CS (Clinical Skills) status and date*

## Education Commission for Foreign Medical Graduate Certification

*ECFMG certification date*

- ☐ My medical education does not require my certification by the ECFMG.

## ACGME Accredited Internship

*Specialty of internship program*

*Institution and dates of training*

*Program director*

*Mailing address, telephone, and fax number of program director*

- ☐ I have not completed, or entered, any other internship program.
- ☐ My training in this or any other internship was not extended or interrupted.
- ☐ All other internship programs completed or entered are described completely in additional comments.
- ☐ All extensions or interruptions of my training in this or any other internship are described completely in additional comments.

## ACGME Accredited Residency

*Specialty of residency program*

*Institution and dates of training*

*Program director*

*Mailing address, telephone, and fax number of program director*

- [ ] I have not completed, or entered, any other residency program.
- [ ] My training in this or any other residency was not extended or interrupted.
- [ ] All other residency programs completed or entered are described completely in additional comments.
- [ ] All extensions or interruptions of my training in this or any other residency are described completely in additional comments.

## Previous Fellowship Training Experience, ACGME Accredited and Non-ACGME Accredited

*Fellowship specialty or sub-specialty*

*Institution and dates of training*

*Program director*

*Mailing address, telephone, and fax number of program director*

- [ ] I have not completed, or entered, any other fellowship or sub-specialty program.
- [ ] My training in this or any other fellowship or sub-specialty programs was not extended or interrupted.
- [ ] All other fellowship or sub-specialty programs completed or entered are described completely in additional comments.
- [ ] All extensions or interruptions of my training in this or any other fellowship or sub-specialty programs are described completely in additional comments.

## American Board of Medical Specialty Certification

*ABMS specialty or sub-specialty board, certificate number, date of certification, and date of expiration*

- [ ] I present further ABMS specialty or sub-specialty board certification information in additional comments.

## American Board of Medical Specialty Certification Eligibility

*ABMS specialty or sub-specialty board, and date of termination of eligibility*

- [ ] I present further ABMS specialty or sub-specialty board eligibility information in additional comments.

## Non-ABMS Recognized Sub-Specialty Certification

*Non- ABMS recognized sub-specialty board, and date of expiration*

- [ ] I present further non-ABMS recognized sub-specialty board certification information in additional comments.

## Research Activity

☐ I have not participated in research activity to date.

☐ All research activity is described completely in additional comments.

## Scholarly Activity

☐ I have no published, accepted, or submitted papers, presentation, or abstracts.

☐ All published, accepted, and submitted papers, presentations, and abstracts are described completely in additional comments.

## Licensed Medical Practice and/or Health Care Provider Experience

☐ I have no previous experience as a licensed medical practitioner or health care provider other than as a trainee.

☐ All previous medical practice and/or health care provider experience other than as a trainee is described completely in in additional comments.

## State Medical Licensure

___

*Present state licensure, type of license, and expiration date*

☐ Neither this nor any other state has ever placed or considered placing limitations upon my license to practice medicine.

☐ Current and/or prior limitations upon my license to practice medicine in this or any other state are described completely in additional comments.

## Advanced Cardiac Life Support Certification (ACLS)

___

*Advanced Cardiac Life Support (ACLS) certification expiration date*

☐ I am not currently certified in Advanced Cardiac Life Support (ACLS).

## Drug Enforcement Administration (DEA)

___

*Drug Enforcement Administration (DEA) registration # and expiration date*

☐ The Drug Enforcement Administration (DEA) has never limited or considered limiting my practice of prescribing medication.

☐ Current and/or prior limitations placed or considered by the Drug Enforcement Administration (DEA) regarding my practice of prescribing medication are described completely in additional comments.

## Military, Other Governmental, or Non-Governmental Organization Participation or Obligation

☐ I have not participated in, and am not participating in or have an outstanding obligation to, any U.S. or non-U.S. military, other governmental, or non-governmental organizations.

☐ My current and/or prior participation in or obligation to all U.S. or non-U.S. military, other governmental, or non-governmental organizations is described completely in additional comments.

## Medical Malpractice History

☐ I have no history of resolved, active, pending, or currently considered medical malpractice actions.

☐ All resolved, active, pending, and currently considered medical malpractice actions are described completely in additional comments.

## Substance Abuse

- [ ] I do not have, nor have I ever had, any occurrence of substance mis-use, abuse, and/or dependency, and I am not currently, nor have I ever been, suspected of experiencing substance mis-use, abuse, or dependency.
- [ ] My history of occurrence or suspicion of substance mis-use, abuse, and/or dependency is described completely in additional comments.

## Felonious Activity or Felony Conviction

- [ ] I have never been charged with, prosecuted for, or convicted of a felony or felonious activity.
- [ ] All charges of, prosecutions for, or convictions of felonies or felonious activity are described completely in additional comments.

## Sections of this Application that I Further Describe in Additional Comments

- [ ] **Medical Education**
- [ ] **ACGME Accredited Internship**
- [ ] **ACGME Accredited Residency**
- [ ] **Previous Fellowship Training Experience, ACGME Accredited and Non-ACGME Accredited**
- [ ] **American Board of Medical Specialty Certification**
- [ ] **American Board of Medical Specialty Certification Eligibility**
- [ ] **Non-ABMS Recognized Sub-Specialty Certification**
- [ ] **Research Activity**
- [ ] **Scholarly Activity**
- [ ] **Licensed Medical Practice and/or Health Care Provider Experience**
- [ ] **State Medical Licensure**
- [ ] **Drug Enforcement Administration (DEA)**
- [ ] **Military, Other Governmental, Non-Governmental Organization Participation or Obligation**
- [ ] **Medical Malpractice History**
- [ ] **Substance Abuse**
- [ ] **Felonious Activity or Felony Conviction**

## Curriculum Vitae

- [ ] I present my curriculum vitae (CV) attached.

## Certification

I certify that the information presented within my application and curriculum vitae is complete and accurate. I acknowledge and agree that my submitting incomplete, misleading, or inaccurate information disqualifies me from consideration for, or if appointed from continued participation in, this training appointment.

| ______________________________ | ______________________________ |
|---|---|
| *Certifying signature of applicant* | *Date of certifying signature* |