Critical Care Medicine Fellowship Program Application Form
University of Kentucky Department of Anesthesiology
Lexington, Kentucky 40536-0293
(859) 323-5956

| Section 1. Critical Care Medicine Fellowship Program | | | |
|---|---|---|---|
| Applying for a position beginning in: | | | |
| **Section 2. Personal Data** | | | |
| Name: Last | First: | Middle: | Social Security Number: |
| Present Address: Number and Street | City/State: | | Zip Code: |
| Home Phone Number: | Cell Phone Number: | Email Address: | |
| Permanent Contact (c/o name): | Permanent Address: Number and Street | | |
| Permanent Phone Number: | City/State: | | Zip Code: |
| Date of Birth:<br>Place of Birth: | Gender:<br>Male ☐<br>Female ☐ | Citizenship Status:<br>US ☐<br>Other ☐ | Visa Type: (if applicable)<br>Permanent ☐<br>Temporary-Specify Below:<br>J-1 ☐ H-1 ☐ Other:_____ |

| Section 3. Examinations | | | | | |
|---|---|---|---|---|---|
| USMLE Step 1 | | USMLE Step 2 | | USMLE 3 | |
| Date: | Score: | Date: | Score: | Date: | Score: |
| COMLEX 1 | | COMLEX 2 | | COMLEX 3 | |
| Date: | Score: | Date: | Score: | Date: | Score: |
| NBME Part 1 | | NBME, Part 2 | | NBME, Part 3 | |
| Date: | Score: | Date: | Score: | Date: | Score: |
| In-Training Exams | | | | | |
| Date: | Score: | Date: | Score: | Date: | Score: |
| ECFMG Certificate Date: | | ECFMG No. | | | |

| Section 4. Board Certification | |
|---|---|
| Board Certification Type | Year |
| | |
| | |



UKHealthCare

| Section 5. Licensure | |
|---|---|
| Licensure State | Date Granted |
| | |
| | |
| | |

| Section 6. Education | | | | | |
|---|---|---|---|---|---|
| Institution Name | Institution Location | Dates Attended From(mo/yr): | To: (mo/yr) | Degree Conferred | Area of Study/Major |
| Undergraduate: | | | | | |
| Undergraduate: | | | | | |
| Medical School: | | | | | |
| Graduate Work (Master's or Doctoral): | | | | | |
| Graduate Work (Master's or Doctoral): | | | | | |
| Scholarships/Honors/Awards: | | | | | |

| Section 7. Graduate Medical Education | | | | |
|---|---|---|---|---|
| Institution Name | Institution Location | Type | Dates Attended From (mo/yr) | To (mo/yr) |
| Internship: | | | | |
| Residency: | | | | |
| Fellowship: | | | | |

| Section 8. Other Medical Experience | | |
|---|---|---|
| Type | Location | Dates |
| Type | Location | Dates |

| Section 9. Letters of Reference Requested | |
|---|---|
| 1. Chairman or Equivalent (Name) | |
| Institution and Address | |
| 2. Program Director (Name) | |
| Institution and Address | |
| 3. Faculty Member (Name and Title) | |
| Institution and Address | |
| Please check one:<br>☐ I hereby waive access to the above letters and will so inform the authors.<br>☐ I desire access to the above letters and will so inform the authors. | |
| Signature of Applicant | |
| I certify that the information submitted on these application materials is complete and correct to the best of my knowledge. I understand that any false or missing information may disqualify me for this position | |
| Signature: | Date: |