

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

Section 1. Pain 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:		Gender: Male <input type="checkbox"/>	Citizenship Status: US <input type="checkbox"/>	Visa Type: (if applicable) Permanent <input type="checkbox"/>	
Place of Birth:		Female <input type="checkbox"/>	Other <input type="checkbox"/>	Temporary-Specify Below: J-1 <input type="checkbox"/> H-1 <input type="checkbox"/> 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		

Section 5. Licensure	
Licensure State	Date Granted

Section 6. Education					
Institution Name	Institution Location	Dates Attended		Degree Conferred	Area of Study/Major
		From (mo/yr):	To: (mo/yr)		
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. Faculty Member (Name and Title)

Institution and Address

2. Faculty Member (Name and Title)

Institution and Address

3. Faculty Member (Name and Title)

Institution and Address

Please check one:

I hereby waive access to the above letters and will so inform the authors.

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: