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: Place of Birth:	Gender: Male ☐ Female ☐	Citizenship Status: US ☐ Other ☐	Visa Type: (if applicable) Permanent ☐ Temporary-Specify Below: 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. 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: