Wexner Medical Center

Ambulatory Anesthesiology/Business Fellowship Application
915 Olentangy River Rd, Columbus, OH 43212

attn: Taylor Stein

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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)

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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*