

Orthopedic Anesthesia Fellowship Application

For Office Use Only

Photo
(passport size)

University of Michigan
Department of Anesthesiology
1H247 UH, SPC 5048
1500 E Medical Center Drive
Ann Arbor, MI 48109-5278

Received _____
Reviewed _____
Interviewed _____
Result _____

Note: Please type or print clearly

Fellowship beginning _____, _____ Date of application ____/____/____

Name _____
last first middle

Present address _____
street city state zip code

Phone (home) _____ (work) _____ (mobile) _____
include city/country code if applicable

Permanent address _____
street city state zip code

Citizenship _____ Place of birth _____
city/state/country

Social security no. _____ - _____ - _____ E-mail _____

Nearest relative _____

Address _____

Phone day _____ Evening _____

Name _____

EDUCATION

UNDERGRADUATE COLLEGES (other than medical school)

Name	Address	Degree	Month/Year
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GRADUATE SCHOOL (other than medical school)

MEDICAL SCHOOL

Name	Years Attended	Degree	Month/Year
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INTERNSHIP

PGY 1 _____

Hospital	Address
----------	---------

Type	From	To
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RESIDENCY

PGY 2 _____

Hospital	Address
----------	---------

Type	From	To
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PGY 3 _____

Hospital	Address
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Type	From	To
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PGY 4 _____

Hospital	Address
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Type	From	To
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PGY 5 _____

Hospital	Address
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Type	From	To
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Name _____

FELLOWSHIPS: (other)

_____	Dates
_____	Dates

LICENSED IN THE STATE OF _____ Year _____

ECFMG - Number _____ Year _____

VQE - Number _____ Year _____

FMGEMS - Number _____ Year _____

OTHER: Type of Visa _____ Year _____

MILITARY STATUS

Branch: _____ Dates _____

Future Obligation: YES NO

Explain: _____

RESEARCH PROJECTS

Project	Place	Year
see CV		

PUBLICATIONS

see CV

PRESENTATIONS

see CV

Name _____

AWARDS AND HONORS

see CV

PREVIOUS EXPERIENCE (other than in medicine)

To complete your application, please arrange for the following to be sent to the address below.

1. Official Medical School Transcript & Diploma
2. Curriculum Vitae
3. Personal Statement (one page)
4. Three Letters of Professional Reference (including one from the Director of your training program)

LIST NAMES AND INSTITUTIONS/ADDRESSES:

1. _____
2. _____
3. _____

Applicant Signature

Date

The application must be completed in its entirety, or it cannot be processed.

Application and all related communications should be addressed to:

**Douglas Anderson, MD
University of Michigan
Department of Anesthesiology
1H247 UH, SPC 5048
1500 East Medical Center Drive
Ann Arbor, MI 48109-5278**