

STANFORD UNIVERSITY MEDICAL CENTER  
 STANFORD, CALIFORNIA 94305-5640  
 (650) 723-6415

**APPLICATION FOR CLINICAL FELLOWSHIP IN ANESTHESIA**  
*(Please... COMPLETE ALL SECTIONS)*

(Check boxes: If completing this form on the computer, double-click a box to select it, and then double-click "checked".)

<b>APPLICATION DATE</b>	<b>START DATE:</b>	<b>TYPE of FELLOWSHIP PROGRAM DESIRED:</b>
Name _____	( <input type="checkbox"/> MD, <input type="checkbox"/> PhD, <input type="checkbox"/> Other _____)	Work Phone _____
Address _____		Work Fax _____
		Pager _____
Home Phone: _____	Cell Phone: _____	Email: _____
Citizenship _____	(If "USA", <input type="checkbox"/> Native born or <input type="checkbox"/> Naturalized)	Birth date _____
Birthplace: City: _____	State/Province: _____	Country: _____
VISA type/status	<input type="checkbox"/> J-1 <input type="checkbox"/> EAD <input type="checkbox"/> PERM. RESIDENT	
US Social Security # _____		
NPI #: <a href="#">(National Provider Identifier)</a>		
The Administrative Simplification provisions of the <i>Health Insurance Portability and Accountability Act of 1996 (HIPAA)</i> mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the <b>National Plan and Provider Enumeration System (NPPES)</b> to assign these unique identifiers.		
If you do not have an NPI #, please go to the following website to apply for one: <a href="https://nppes.cms.hhs.gov/NPPES/Welcome.do">https://nppes.cms.hhs.gov/NPPES/Welcome.do</a>		
<b>PERSON FOR PERMANENT CONTACT:</b>		
Name: _____	Phone: _____	
Address: _____		

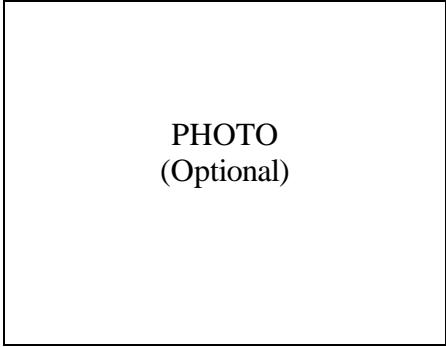
**SUPPLEMENTAL INFORMATION**

Please note that Stanford University Medical Center is committed to increasing representation of women and members of minority groups in its residency and fellowship training programs, and particularly encourages applications from such individuals. The Department of Anesthesia fully supports this policy. You are invited to identify, from the list below, your racial/ethnic background. Your choice to provide or not to provide this information will in no way affect your application.

<b>SCORES FROM USMLE/NATIONAL BOARD</b> <i>(PLEASE PROVIDE COPY OF ACTUAL SCORES)</i>	#1	#2	#3
<b>SCORES FROM YOUR ITE (IN-TRAINING EXAM)</b> <i>Given by the ASA/ABA for those who have done an anesthesia residency</i> <i>PLEASE PROVIDE THE NATIONAL PERCENTILE SCORE</i>  <i>(PLEASE PROVIDE COPY OF ACTUAL SCORES)</i>	#1	#2	#3

**ETHNIC GROUP**

- African American
- American Indian or Alaska Native
- Caucasian
- Asian/Pacific Islander
- Hispanic - Mexican/American or Chicano
- Hispanic - Puerto Rican (Mainland)
- Hispanic - Puerto Rican (Commonwealth)
- Hispanic - Other Hispanic



**EDUCATION & TRAINING**

<b>COLLEGE or UNIVERSITY</b>	<b>MAJOR</b>	<b>DEGREE</b>	<b>YEARS</b>	<b>SCHOLARSHIPS/HONORS</b>

<b>MEDICAL SCHOOL</b>	<b>YEARS</b>	<b>SCHOLARSHIPS/HONORS</b>

**POSTGRADUATE TRAINING & EXPERIENCE**

	<b>PROGRAM/CITY</b>	<b>TYPE</b>	<b>DATES</b>
<b>INTERNSHIP</b>			-
<b>RESIDENCY</b>			-
<b>RESIDENCY</b>			-
<b>FELLOWSHIP</b>			-
<b>PRACTICE</b>			-
<b>MEDICAL LICENSURE</b>			
State:		Number:	
		Expires:	

State:		Number:		Expires:	
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**ANESTHESIA EXPERIENCE**

Operating Room \_\_\_\_\_

Other (ICU, OB, Pain, etc) \_\_\_\_\_

**ANESTHESIA SUB-SPECIALTY of INTEREST and WHY**

**SIGNIFICANT NON-MEDICAL EXPERIENCE** (*Community Service, Work Experience, etc.*)

**RESEARCH EXPERIENCE** (*Indicate Undergraduate, Graduate, and Medical School*)

**PUBLICATIONS** (*You may reference your CV*)

**FUTURE PROFESSIONAL PLANS**

IF MORE SPACE IS REQUIRED, PLEASE ATTACH ADDITIONAL PAGES.