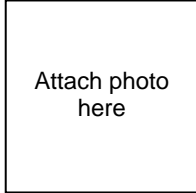


Applying for Academic Year: \_\_\_\_\_ - \_\_\_\_\_

**Application for Fellowship  
Surgical Critical Care  
University of Pittsburgh Medical Center**



**Please check which fellowship you are applying for:**

- \_\_\_\_\_ One Year - Surgical Critical Care
- \_\_\_\_\_ Two Year - Surgical Critical Care/Acute Care Surgery
- \_\_\_\_\_ National Research Service Award (NRSA) T-32 Fellowship  
(please check if you would like more information about the training grant)

**SECTION I**

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Name: \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Email Address: \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Social Security # \_\_\_\_\_ Citizenship \_\_\_\_\_

Birthdate (optional) \_\_\_\_\_ Birthplace \_\_\_\_\_

ECFMG Number \_\_\_\_\_ Valid Through \_\_\_\_\_ (attach copy)  
Visa Status \_\_\_\_\_ Valid Through \_\_\_\_\_

**SECTION II**

**EDUCATION AND TRAINING** (be sure to include all training in the United States)

	<b>Dates of Attendance</b>	<b>Institution Name</b>	<b>Degree Obtained</b>
Premedical	_____	_____	_____

Medical	_____	_____	_____
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	<b>Dates of Training</b>	<b>Institution</b>	<b>Program Director</b>
Internship	_____	_____	_____

Residency	_____	_____	_____
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Fellowship (specify)	_____	_____	_____
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Research or Other	_____	_____	_____
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Graduate Training	_____	_____	_____
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Other Professional Experience or Employment (private practice, moonlighting, etc.)	_____	_____	_____
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\_\_\_\_\_

\_\_\_\_\_

**SECTION III**

Board Certified \_\_\_\_\_ (year) Board Eligible \_\_\_\_\_ (year)  
Subspecialty \_\_\_\_\_  
Board Certified \_\_\_\_\_ (year) Board Eligible \_\_\_\_\_ (year)

**LICENSE INFORMATION**

Current State Medical Licenses (list and attach copies of ALL unrestricted licenses)

State \_\_\_\_\_ State \_\_\_\_\_  
Lic # \_\_\_\_\_ Lic # \_\_\_\_\_  
Expires \_\_\_\_\_ Expires \_\_\_\_\_

Has your state license or application for state license ever been denied, suspended or revoked? \_\_\_\_\_  
Has your membership on a hospital’s medical staff ever been denied, revoked or suspended? \_\_\_\_\_  
Have you ever had you state or federal controlled substance license (DEA) revoked, suspended or denied? \_\_\_\_\_  
Have you ever been convicted of a felony? \_\_\_\_\_  
Have you ever been found guilty of malpractice or negligence? \_\_\_\_\_

If your answer to any of the above questions is affirmative, please attach a letter of clarification.

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**SECTION IV**

DEA Number \_\_\_\_\_ State \_\_\_\_\_ Expires \_\_\_\_\_ (attach copy)  
FLEX exam Part I \_\_\_\_\_ Part II \_\_\_\_\_ Passed? \_\_\_\_\_ (attach copies of FLEX I and II)  
USMLE (indicate successful completion dates) Step 1 \_\_\_\_\_ Step 2 \_\_\_\_\_ Step 3 \_\_\_\_\_  
Attach copies of scores from Steps 1, 2, and 3  
NBME Date Part III of exam taken and passed \_\_\_\_\_ (attach copies of Parts I, II and III)

**ACLS/ATLS CERTIFICATIONS**

ACLS Certification: Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration date: \_\_\_\_\_  
ATLS Certification: Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration date: \_\_\_\_\_

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**LETTERS OF RECOMMENDATION (3)**

Persons from whom you are requesting letters of recommendation. Include the Program Director of your most recent training program and have the letters sent directly to the address below, Attn: Dr. Samuel Tisherman, Program Director.

<u>Name</u>	<u>Position</u>
1.	
2.	
3.	

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Return your application to the following address:  
Samuel A. Tisherman, MD – Program Director  
Department of Critical Care Medicine  
655 Scaife Hall, 3550 Terrace Street  
Pittsburgh, PA 15261  
FAX – 412-578-9340