



APPLICATION FOR ACUTE PAIN MANAGEMENT AND REGIONAL ANESTHESIA (APM & RA) FELLOWSHIP TRAINING IN THE DEPARTMENT OF ANESTHESIOLOGY AT UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE HEALTH SCIENCE CENTER P.O. Box 100254 UFHSC GAINESVILLE, FL 32610-0254 Tel: 352-846-1295

Date \_\_\_\_\_ Date you wish to begin \_\_\_\_\_

1. PERSONAL DATA

Name in Full \_\_\_\_\_ First Middle Last
Current Mailing Address \_\_\_\_\_ Street
City State Zip Email Address
Telephone: Home Office Ext. Cell:
Marital Status Name of Spouse (if applicable)
Sex M F # of Children Total No. of Dependents
Date of Birth (MM/DD/YY) Place of Birth
U.S. Citizen Yes No (see #6) Social Security #:

2. LICENSURE ELIGIBILITY REQUIREMENTS

If you wish to receive credit from the American Board of Anesthesiology, the Board requires that you obtain medical licensure or pass a qualifying examination before beginning your fellowship.

A. Qualifying Examinations

United States Medical Licensing Examination: Step 1 Step 2 Step 3
National Boards: Part I Score Part II Score
Part III Score Number Date
FLEX: State Date

B. Licensure

State of Licensure Date Number

3. EDUCATION AND EXPERIENCE (use separate page if necessary)

Undergraduate Dates
Location Degree
Medical School Graduation Date (Month/Year)

Location \_\_\_\_\_

Honors \_\_\_\_\_ Degree \_\_\_\_\_

Current Employment/training \_\_\_\_\_

List chronologically your activities from the time of graduation from medical school *to the present*. Specify type of internship or post-MD specialty training.

From/To	Activity	Place	Degree, If any	Program Director

Membership in professional societies and others \_\_\_\_\_

**4. MILITARY OBLIGATIONS**

In reserves? \_\_\_\_\_ If yes, what branch? \_\_\_\_\_ Dates of Commitment \_\_\_\_\_

**5. LETTERS OF REFERENCE**

At least three letters of reference are required. One must be from the Residency Director of your Residency Training Program and at least two others should be from physicians who have observed or supervised you during residency or other recent training program, as applicable.

List below the names of all your references and have them write directly to us.

1. \_\_\_\_\_

Name	Address	City	State	Zip

2. \_\_\_\_\_

Name	Address	City	State	Zip

3. \_\_\_\_\_

Name	Address	City	State	Zip

Others: \_\_\_\_\_

**6. CITIZENSHIP (Complete if applicable)**

**IF A NATURALIZED CITIZEN:** Naturalization Certificate Number \_\_\_\_\_

Location \_\_\_\_\_ Date \_\_\_\_\_

**IF NOT A U.S. CITIZEN:**

**Immigrants**

Alien Registration Card No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Non-Immigrant Aliens**

Visa Number \_\_\_\_\_ Type of Visa \_\_\_\_\_

Expiration Date \_\_\_\_\_ Nationality \_\_\_\_\_

### Refugees

If you do not have an alien registration card or a visa, please send us a copy of the card attached to your passport by the Immigration Service and complete the section below:

Country that issued your passport \_\_\_\_\_

Passport No. \_\_\_\_\_ Current status \_\_\_\_\_

Are you a graduate of a foreign medical school?

\_\_\_\_\_

If yes, please give name of school and year of graduation

\_\_\_\_\_

ECFMG Number \_\_\_\_\_ Standard or Interim \_\_\_\_\_

Have you passed the Visa Qualifying Exam (VQE) \_\_\_\_\_ Date of VQE \_\_\_\_\_

\_\_\_\_\_

Have you received licensure from a country other than U.S.

\_\_\_\_\_

If so, Country \_\_\_\_\_ Province \_\_\_\_\_ Date \_\_\_\_\_

International Medical Graduates who are not native American English speakers MUST complete the Test of the Spoken English Language. You must attain at least a score of 55 on this examination or your application for residency cannot be considered.

Evidence of achievement of this score or higher must be submitted or your application will not be considered. You can obtain information about this test from the following website: <http://www.toefl.org/abtse.html>

### 7. Please attach a brief paragraph about your goals as a future APM & RA specialist or please include your goals in your personal statement.

#### ENCLOSE WITH THIS APPLICATION:

Recent Photograph (Passport Type)

Current Curriculum Vitae

Personal Statement

If Applicable: Copy of ECFMG certificate

Copy of Visa (for Non-Immigrant Alien)

Copy Alien registration Card (for Immigrant Non-Citizen)

#### MAIL APPLICATION, ENCLOSURES, AND LETTERS OF REFERENCE TO:

André P. Boezaart M.D., Ph.D.

Professor of Anesthesia and Orthopaedic Surgery

Department of Anesthesiology

Director Acute Pain Medicine and Regional Anesthesia

Director APM & RA Fellowship Program

University of Florida College of Medicine

P. O. Box 100254

1600 SW Archer Road (Courier delivery)

Gainesville, FL 32610

Tel: (352) 846-0913 (Office)

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

AN EQUAL OPPORTUNITY INSTITUTION

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