Society of Critical Care Anesthesiologists
SOCCA

Application for Fellowship in Anesthesia Critical Care Medicine

First Name _____ Middle Name _____ Last Name _____

Desired fellowship start date: Month July Year _____

Email address: _____

Mailing Address

Country _____ Street Address _____

City _____ State/Province _____ Zip Code _____

Preferred phone #: _____ ☐ Home ☐ Work ☐ Mobile

I, the undersigned, attest that the information provided herein is true to the best of my knowledge:

_____

Signature of applicant

_____

Date

Optional

Please attach a recent photo

Please note:

1) You must submit this application separately to each program to which you are applying.

2) Unless specified by a particular program, the ACCM programs are utilizing the services of SF Match (https://sfmatch.org) to coordinate the matching of applicants with programs. Please ensure that you register with SF Match.

Education

College/University #1: _____

Location: _____

Major: _____ Degree earned _____

Dates of Attendance: From Month _____ Year _____ to Month _____ Year _____

College/University #2 (leave blank if not applicable): _____

Location: _____

Field of Study: _____ Degree earned _____

Dates of Attendance: From Month _____ Year _____ to Month _____ Year _____

Medical School #1: _____

Location: _____

Degree earned: _____

Dates of Attendance: From Month _____ Year _____ to Month _____ Year _____

Medical School #2 (leave blank if not applicable): _____

Location: _____

Degree earned: _____

Dates of Attendance: From Month _____ Year _____ to Month _____ Year _____

Current/Prior Advanced Medical Training

For each internship, residency, or fellowship training position you have had or currently hold, regardless of the amount of time spent at each, please provide the requested information. Describe further entries in the space provided at the end of this application.

Entry 1

Type of training: ☐ Internship ☐ Residency ☐ Fellowship

Institution/Program: _____ Specialty: _____

Country: _____ State/Province: _____

Dates of Attendance: From Month _____ Year _____ to Month _____ Year _____

Reason for leaving: ☐ Completed training ☐ Other (please explain at bottom of this page)

Entry 2

Type of training: ☐ Internship ☐ Residency ☐ Fellowship

Institution/Program: _____ Specialty: _____

Country: _____ State/Province: _____

Dates of Attendance: From Month _____ Year _____ to Month _____ Year _____

Reason for leaving: ☐ Completed training ☐ Other (please explain at bottom of this page)

Entry 3

Type of training: ☐ Internship ☐ Residency ☐ Fellowship

Institution/Program: _____ Specialty: _____

Country: _____ State/Province: _____

Dates of Attendance: From Month _____ Year _____ to Month _____ Year _____

Reason for leaving: ☐ Completed training ☐ Other (please explain below)

Citizenship (Note: Proof of citizenship or a permanent immigration visa will be required at time of employment)

☐ I am a U.S. citizen

☐ I am not a U.S. citizen but I have the legal right to remain permanently in the U.S. during the period for which I am applying

Other:

Note: In compliance with federal law, prior to being hired all fellows will be required to verify identity and eligibility to work in the United States.

International Medical Graduates only:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

☐ Yes ☐ No

Date of ECFMG certification: Month _____ Year _____

Intensive Care Unit Experience:

Type (med, med/surg, surg, trauma)	# Months	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Examinations (please submit copies of all scores with application):

USMLE/NBME

#1 _____ #2 _____ #3 _____

In-service training examinations (☐ Anesthesia ITE ☐ Other _____)

#1 _____ #2 _____ #3 _____

Licensure/Certification

For each license you currently hold, please provide the requested information. Describe further entries in the space provided at the end of this application.

Entry #1:

State: _____ License Type: ☐ Full ☐ Temporary ☐ Limited ☐ Inactive

License #: _____ Expiration: Month _____ Year _____

Entry #2 (leave blank if not applicable):

State: _____ License Type: ☐ Full ☐ Temporary ☐ Limited ☐ Inactive

License #: _____ Expiration: Month _____ Year _____

DEA Registration Number (if applicable): _____ Expiration: Month: _____ Year: _____

Are you Board Certified? ☐ Yes ☐ No

Certifying board(s): _____

Life Support Certification

☐ ACLS (Advanced Cardiac Life Support) certified in the United States. Expiration Date: _____

☐ ATLS (Advanced Trauma Life Support) certified in the United States. Expiration Date: _____

Miscellaneous

Has your medical license ever been suspended/revoked/voluntarily terminated?

☐ No ☐ Yes Reason (if checked 'Yes'):

Have you ever been named in a malpractice case?

☐ No ☐ Yes Reason (if checked 'Yes'):

Is there anything in your past history that would *limit* your ability to be licensed or to receive hospital privileges?

☐ No ☐ Yes Reason (if checked 'Yes'):

Have you ever been convicted of a felony?

☐ No ☐ Yes Reason (if checked 'Yes'):

Research Experience (please indicate year(s), mentor(s), Institution, Project Title):

☐ None

Publications (please indicate full citation(s)):

☐ None

Honors/Awards (please indicate date and title received):

☐ None

Was your medical education/training extended or interrupted?

☐ No ☐ Yes Reason (if checked 'Yes'. Please include specific dates that span your gap in education/training):

If you have been employed since leaving your training, please list each position you have held, including nature of practice, types of cases, dates employed, and reason(s) for leaving:

☐ I have continuously been in a training program or I have not been employed since leaving my training

Are you able to carry out the responsibilities of a critical care medicine fellow at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements, including overnight work, without accommodations?

☐ Yes ☐ No Reason (if checked 'No'):

Please provide a personal statement (can copy/paste):

What interests do you have outside of medicine?

Please provide any additional information that you would like us to know about yourself and/or any supplementary information regarding any of the above questions: