PHOTO

(PASSPORT SIZE)

APPLICATION for FELLOWSHIP in

Regional Anesthesiology and Acute Pain Medicine

ANDREWS | RESEARCH & EDUCATION FOUNDATION

FOR OFFICE USE ONLY
Received _____
Reviewed _____
Interviewed _____
Result _____

NOTE: Please type or print clearly all entries

FELLOWSHIP BEGINNING _____/_____ (Month/Year) DATE OF APPLICATION _____

☐ **Applying for 1 Year Clinical Fellowship**

NAME: _____ / / _____
Last First Middle D.O.B.: Month Day Year

PRESENT ADDRESS: _____
Street City State Zip Code

PHONE: HOME:_____ (include City and Country Code if applicable) WORK / PAGER: _____

PERMANENT ADDRESS: _____
Street City State Zip Code

CITIZENSHIP : _____ PLACE OF BIRTH : _____ (City / State / Country)

E-MAIL: _____ SINGLE: _____ MARRIED : ___

NEAREST RELATIVE NAME (S) _____

ADDRESS: _____
Street City State Zip Code

PHONE: DAY_____ EVENING _____

EDUCATION

UNDERGRADUATE COLLEGES (other than medical school)

Name | Address | Degree | Month/Year

_____

_____

GRADUATE SCHOOL (other than medical school)

_____

MEDICAL SCHOOL

Name | Years Attended | Degree | Month/Year

_____

_____

INTERNSHIP

PGY 1 _____

Hospital | Address

_____ _____

Type | From | To

RESIDENCY

PGY2 _____

Hospital | Address

_____ _____

Type | From | To

PGY3 _____

Hospital | Address

_____ _____

Type | From | To

PGY4 _____

Hospital | Address

_____ _____

Type | From | To

PGY5 _____

Hospital | Address

_____ _____

Type | From | To

FELLOWSHIPS: (other) _____

Dates

_____

Dates

FLORIDA STATE LICENSE _____ Year _____Expires_____

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 PLACE YEAR

☐ See CV

PUBLICATIONS: (list and provide reprints)

☐ See CV

PRESENTATIONS: (list)

☐ See CV

AWARDS AND HONORS:

PREVIOUS EXPERIENCE: (other than in medicine)

ADDITIONAL DOCUMENTATION REQUIRED

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

I. Official Medical School Transcript & Diploma
II. Current Curriculum Vitae
III. Personal Statement – A brief narrative (approximately 250 words) explaining your reason for pursuit of a Fellowship in Regional Anesthesia
IV. Please provide a brief description (approximately 250 words) of one or more proposed academic activities you would like to embark upon during your fellowship year. (Optional)
V. Three Letters of Professional Reference
(including one from the Director of your Current Training Program)

LIST NAMES AND INSTITUTIONS/ADDRESSES:

1. _____

_____

2. _____

_____

3. _____

_____

I certify that the foregoing information is accurate to the best of my knowledge. I agree to notify Andrews Institute of any change in my status by May 1st of the year I have applied to commence my Fellowship.

_____
SIGNATURE OF APPLICANT

_____
DATE

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

APPLICATION AND ALL RELATED COMMUNICATIONS SHOULD BE ADDRESSED TO:

Scott Thomas, MD
The Andrews Institute ASC
1040 Gulf Breeze Parkway, Suite 100
Gulf Breeze, FL 32561
FAX: 1-866-847-6855

E-Mail: **scott.thomas33@yahoo.com**