Application for Fellowship
Critical Care Medicine (Internal Medicine)
Washington University School of Medicine

Attach Photo Here

Applying for Academic Year: _____ - _____

Indicate duration:

_____ 1 year (available to trainees who have completed subspecialty training in Nephrology, Cardiology, Pulmonary Disease or Infectious Disease)

_____ 2 years

Name:
Last, First MI _____

Address: _____

City, State, Zip: _____

E-mail Address: _____

Home Phone: _____

Cell Phone: _____

Social Security: _____

Citizenship: _____

Date of Birth: _____

Birth Place: _____
ECFMG Number:
Valid Though: _____
Visa Status:
Valid Through: _____

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

Institution and Location	**Dates Attended**	**Degree**	**Field of Study**

Training
Internship

Dates	Institution	Program Director

Residency

Dates	Institution	Program Director

Fellowship

Dates	Institution	Program Director

Research/Other

Dates	Institution	Program Director

Other Professional Experience or Employment (private practice, moonlighting, etc.)

Dates	Institution	Role

Medical School Awards

Membership in Honarary/Professional Societies

Board Certified	Specialty	Year

LICENSE INFORMATION

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

State	License Number	Expiration Date

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.

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: _____

HOBBIES & INTERESTS

_____

_____

OTHER AWARDS/ACCOMPLISHMENTS

_____

_____

LETTERS OF RECOMMENDATION (3)

Include the Program Director of your most recent training program and have the letters sent directly to the address below, Attn: Dr. Tonya Russell, Program Director:

	Name	Position
1.		
2.		
3.		

Signature of Applicant Date

_____ _____

I certify that the information contained within my application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a fellowship position, or if employed, may constitute cause for termination from the fellowship program.

Return your application to the following address:
Lisa Wetzel
Fellowship Coordinator
Washington University School of Medicine
Pulmonary and Critical Care Division
Box 8052, 660 S. Euclid Ave.
St. Louis, MO 63110
FAX: 314 454 7524

Required Documents:

- Curriculum Vitae
- Department of Medicine Chair's Letter of Support
- At Least Three (3) Letters of Recommendation
- USMLE Result(s)
- Personal Statement
- Photograph

If you have questions about the process or about the status of your application, please contact our fellowship coordinator, Lisa Wetzel (314)454-8762 lwetzel@dom.wustl.edu