

**UNIVERSITY OF CALIFORNIA SAN FRANCISCO
SCHOOL OF MEDICINE
SAN FRANCISCO, CALIFORNIA 94143**

Application for Critical Care Medicine Fellowship

Return completed application to:

Division of Pediatric Critical Care Medicine
University of California, San Francisco, Box 0106
505 Parnassus Avenue, Moffitt 680
San Francisco, CA 94143-0106

Applying for Academic Year _____

NOTE: If you are applying to more than one department you will need to complete a separate application)n for each department.

PLEASE TYPE

Name _____ Department _____

Position: First year Post-M.D. _____ Resident _____ Starting Date _____

Permanent mailing address _____

Present Mailing Address _____

Telephone Numbers Home _____ Hospital _____

Licensed to practice Medicine in State of _____ License No. _____

Passed National Boards Part I ___ yes ___ no Part II ___ yes ___ no Part III ___ yes ___ no
Passed FLEX examination ___yes ___no

If you are a Foreign Medical Graduate have you passed the:

FMGEM ___yes ___ no Certificate Date _____ Certificate Number _____
VQE ___yes ___ no Certificate Date _____ Certificate Number _____

Proof of U.S. citizenship or eligibility for U.S. employment will be required upon hire in accordance with regulations established pursuant to the Immigration Reform and Control Act of 1986.

EDUCATION

Premedical / preosteopathic _____ Dates _____ Degree _____

Other _____ Dates _____ Degree _____

Medical / Osteopathic _____ Dates _____ Degree _____

Internship _____ Dates _____ Degree _____
Hospital _____ Chief of Service _____

Residencies (if any)

_____ Dates _____ Degree _____
Hospital _____ Chief of Service _____

_____ Dates _____ Degree _____
Hospital _____ Chief of Service _____

PRIVACY NOTIFICATION STATEMENT

The information collected is used to satisfy the educational mission of the University and its legal obligations, including determination of eligibility, assessment and evaluation of professional qualifications.

With the exception of the Affirmative Action data, all information requested is mandatory. If the information is not provided the application will be deemed incomplete and not considered by the Program. The information you provide will be reviewed by the Departmental Residency selection committee and may be released pursuant to applicable Federal or State law. The privacy of your file will be the responsibility of the Department.

Individuals have the right to review their own record in accordance with the Information Practices Act and University policy. Information on these policies may be obtained from the training Program to which you have applied and where your file is maintained.

I hereby authorize representatives of the School of Medicine to contact any or all of my former employers, educational institutions attended, or other persons or organizations determined to have information relevant to my application for clinical training. I further consent to such persons and organizations releasing relevant information to the School of Medicine, notwithstanding that it might otherwise be confidential. I understand that any information obtained by the School of Medicine will be treated as confidential personal information. I hereby certify that I have read and understood all statements and questions on this application and that my responses are true and complete to the best of my knowledge. If employed I understand that falsification of this record may be considered cause for my termination.

Signature of Applicant

Date

INFORMATION ON ACADEMIC POLICIES AT UCSF

For up-to-date information, please visit: <http://medschool.ucsf.edu/gme/hsbooklet/index.aspx>. Please contact our office if you would like a hardcopy of the policy.