UCDAVIS
HEALTH SYSTEM

Pain Medicine Fellowship Application

GENERAL INSTRUCTIONS: Complete this application to apply for either a full-time Military Funded or JANUARY appointment to the University of California, Davis Pain Medicine Fellowship Program. In addition to the completed application forwarded by E-mail, please submit a copy of all requested documents from the **CHECKLIST** on the last page of this document to the Fellowship Coordinator: Mureen Darrington; UC Davis Medical Center; Division of Pain Medicine; 4860 Y Street, Suite 3020; Sacramento, CA 95817. If you have any questions, please call 916-734-6824 or e-mail PainFellowship@ucdmc.ucdavis.edu. Materials submitted separately must contain the same last name as the application form.

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Last Name First Middle

Fellowship Start Date

☐ *Military Funded ☐ January 20 ____

PLEASE SEE OUR WEBSITE FOR ALL INFORMATION REGARDING OUR PROGRAM

Policies Regarding Approval:

A. Foreign applicants who are not U.S. citizens, Permanent Residents, Refugee or Asylee must have a current J-1 visa. H-1B visa's are currently NOT accepted by the University of California. For details, please go to: http://www.ucdmc.ucdavis.edu/gme/img_req/index_img_req.html

B. A Fellowship appointment is contingent upon obtaining both a California Medical License and DEA License and possessing current ACLS and Fluoroscopy certificates.
   a. Applicants must have passed USMLE or COMLEX Steps 1, 2 and 3 (or the equivalents) in order to qualify for a California Medical License.
   b. The University of California does not grant "temporary", "training", or "institutional" licenses.

C. The University of California does not discriminate with regard to sex, race, color, age, creed, or national origin in judging an applicant's qualifications for admission.

I. Current or completed residency:

☐ Anesthesiology
☐ PM&R
☐ Internal Medicine
☐ Other _____
☐ Neurology
☐ Psychiatry
☐ Surgery

*Military funded individuals need to provide evidence of funding.

Click to
Insert Photo

II. USMLE or COMLEX Board Score Information

	☐ USMLE ☐ COMLEX STEP 1	☐ USMLE ☐ COMLEX STEP 2	☐ USMLE ☐ COMLEX STEP 3
Score/Percentile			
Number of attempts			
Date of successful completion			

Board Certified Specialties (if applicable) _____ Year Certified _____ Expiration date _____

III. Biographical Information

_____ ☐ MD ☐ DO ☐ Other _____
Name

( ) _____ ( ) _____ - - _____
Home Telephone Cell Telephone Social security #

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Country Email

_____ _____ _____
Alternate E-mail Date of Birth Place of Birth (City, State, Country)

Gender ☐ Male ☐ Female Are you a U.S. Citizen? ☐ Yes ☐ No

If you are not a U.S. Citizen, do you have U.S. Permanent Resident Status? ☐ Yes ☐ No

Country of Citizenship _____
If you are not a U.S. citizen or U.S. permanent resident, please download the following document:
http://www.ucdmc.ucdavis.edu/gme/img reg/index img reg.html

IV. Professional Data

a. Has your license to practice medicine in the U.S. ever been denied, limited, suspended, revoked, or not renewed?
☐ Yes ☐ No If yes, please explain: _____

b. Have any disciplinary actions been initiated or are any pending against you by the State Licensure board?
☐ Yes ☐ No If yes, please explain: _____

c. Has your Federal/State controlled substances or narcotics registration ever been limited, revoked, suspended or not renewed, voluntarily or involuntarily, and is such registration subject to any pending challenge?
☐ Yes ☐ No If yes, please explain: _____

d. Have you ever been convicted of a felony?
☐ Yes ☐ No If yes, please explain: _____

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_____ _____ _____
Last Name First Middle

	Institution Name, City, State	Degree	Dates (M/Y – M/Y)
Undergraduate			

	Institution Name, City, State	Degree	Dates (M/Y – M/Y)
Medical School			

	Program/Hospital Name, City, State	Specialty	Dates (M/Y – M/Y)
Internship			

	Program/Hospital Name, City, State	Specialty	Dates (M/Y – M/Y)
Residency			
Residency			

	Institution Name, City, State	Degree	Dates (M/Y – M/Y)
Graduate (If applicable)			

	Program/Hospital Name, City, State	Dates (M/Y – M/Y)
Research Experience		
Research Topic		
Duties		

	Program/Hospital Name, City, State	Dates (M/Y – M/Y)
Research Experience		
Research Topic		
Duties		

Publications/Honors/Awards

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Last Name | First | Middle

LETTERS OF RECOMMENDATION, IN ADDITION TO THE DEANS'S LETTER, HAVE BEEN REQUESTED FROM THE FOLLOWING INDIVIDUALS: (All letters must be on letterhead with the recommender's signature or e-signature)

Last Name	Title	Institution	Address

☐ I hereby waive the right to access the above letters and will so inform the authors.

☐ I hereby reserve the right to access the above letters and will so inform the authors.

By typing your name below you are submitting an e-signature which will act as your signature confirming your understanding and adherence to the following statement:

I have read and I understand the instructions for completing this application. I certify that the information submitted in this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me for this position.

Signature of Applicant

Date

CHECKLIST (Check each completed item)
Applicant should arrange for the items below to be mailed directly to the Fellowship Director

- [x] 1. THREE LETTERS OF RECOMMENDATION: Letters must be signed originals sent directly to Dr. Singh. One letter MUST be from either the Residency Director or the Department Chairperson. Letters must be dated no more than one year prior to the application date. Letters must reflect appointment at the appropriate academic level and must be from persons qualified to comment on your qualifications in a patient-care setting.
- [x] 2. TRANSLATIONS (if applicable): Documents in a language other than English must be accompanied by a certified translation.
- [x] 3. Universal application
- [ ] 4. CURRENT Curriculum Vitae (CV). (Somewhere in your CV, please supply all Information requested below. Additional information may be included if deemed pertinent)
- [ ] 5. List all GRADUATE MEDICAL EDUCATION TRAINING in chronological order. Include (a) month/year of attendance and (b) the name (do not abbreviate) and address of the sponsoring institution.
- [ ] 6. List all COLLEGES AND UNIVERSITIES ATTENDED in chronological order. Include (a) month/year of attendance, (b) the name (do not abbreviate) and address of the institution, (c) major field of study, (d) degree awarded and (e) date the degree was awarded.
- [ ] 7. PROFESSIONAL EXPERIENCE, if applicable. List in chronological order. Include (a) date of position held, (b) the name (do not abbreviate) and address of the institution and (c) title/position held.
- [ ] 8. American specialty BOARD CERTIFICATIONS, if applicable. Include (a) American board name, (b) date of certification and (c) date of expiration.
- 9. If BOARD ELIGIBLE, include (a) American Board name and (b) month/year of certifying examination.
- 10. List all active and inactive MEDICAL LICENSES, if applicable. Include (a) license number, (b) year issued, (c) date of expiration and (d) photocopy of active medical license(s).
- [ ] 11. DEA registration number, if applicable. Include a Photocopy of certificate.
- [ ] 12. List any pertinent PUBLICATIONS and PRESENTATIONS
- [ ] 13. List any pertinent AWARDS and HONORS.
- 14. PHOTOCOPIES of (a) USMLE, COMLEX, FLEX or NMBE exam scores; and (b) active medical license; and (c) DEA registration certificate.

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