

# Application for Postgraduate Training in Anesthesiology

## University of Michigan

Please Print

Date of Application:

Applying through NRMP:  Yes  No Match #

Subspecialty Interest:

Beginning July 1, 200\_  CA-1  CA-2  CA-3  Fellowship

Social Security Number:

Citizenship:

Name:

*Last* *First* *Middle*

Address:

Telephone: Home Hospital

Person To Contact In Case of Emergency:

Address:

Phone:



University of Michigan Medical Center  
Department of Anesthesiology  
1H247 University Hospital/Box 0048  
1500 East Medical Center Drive  
Ann Arbor, MI 48109-0048  
Telephone: (734) 936-4280  
Fax: (734) 936-9091

## Education

Institution Full Name

City and State

Year Graduated

Pre-Med:

Medicine:

## Postgraduate Training

Institution Full Name

Program

Dates

1st Year Postgraduate:

2nd Year Postgraduate:

3rd Year Postgraduate:

Board Certified or Eligible?

## Examinations *(Please send copies of scores)*

National Boards: **Part I:** Date Score **Part II:** Date Score

Flex Examination: Date Score

Medical License: State Expiration Date Number

## ***Personal Statement***

Why are you applying to this program?

In what specific ways do you think you can contribute to this program?

What are your career plans at present?

What interests do you have outside of medicine?

## ***Instructions***

Medical student applicants must request *one* letter from the Dean of Medical School to be sent directly to this office with official transcripts and *three* letters of recommendation from medical school faculty members.

Applicants who have completed any postgraduate training are to submit *one* letter from the Dean of the Medical School, *one* letter from the chair of the department in which they trained, and *two* letters from attending physicians on the teaching faculty.

All applicants must submit a curriculum vitae.

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Signature

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Date



Dear Prospective Applicant:

Thank you for your interest in the Pediatric Anesthesiology Fellowship Training Program at the University of Michigan Health System. Please return the residency application that is provided within this web page. The information we require is as follows:

- Completed Application
- Curriculum Vitae (with all time accounted for since Medical School - no gaps of time)
- Personal Statement
- Three (3) letters of recommendation (one letter from your current Program Director and two others from faculty in your current program)
- Intraining exam scores
- USMLE and/or COMLEX Transcript (not pass/fail - we want the scores)
- ECFMG Certificate valid Indefinitely (if applicable)
- Current licensure information (even if you hold a limited license or are licensed through your current institution)
- BLS/ACLS/PALS Information (copies of current card with expiration date)

Please address your letters to:

**Paul I. Reynolds, MD**

*Program Director - Pediatric Anesthesiology Program*

Pediatric Anesthesiology - Room F3900 Mott Hospital  
University of Michigan Health System  
1500 East Medical Center Drive SPC 5211  
Ann Arbor, MI 48109-5211

Again, thank you for your interest in the Pediatric Anesthesiology Fellowship Program here at the University of Michigan Health System. If you require further information, please do not hesitate to contact our office at (734) 936-0125.

Sincerely,

Colleen Rauch  
Pediatric Anesthesiology Program Coordinator