

Mass General Cardiac Anesthesia Fellowship Application

Thank you for your interest in the Mass General Cardiac Anesthesia Fellowship.

Prior to our review of your application we ask that you send the following documents to our office:

1. Personal statement
 - a. Describe your interest in the Cardiac Anesthesia Fellowship
 - b. Describe plans after completion of the fellowship
2. Completed Application
3. A current Curriculum Vitae or resume
4. Three letters of recommendation. One letter must be from your residency program director.

Send all correspondence to:

Michael G. Fitzsimons, M.D., FCCP
Director, Cardiac Anesthesia Fellowship
Division of Cardiac Anesthesia
Department of Anesthesia and Critical Care
Massachusetts General Hospital
55 Fruit Street
Boston, MA 02114
(617) 726-8980
mfitzsimons@partners.org

Once all applications are received a decision about an interview will be made. Interviews for the following academic year start in May. Please do not hesitate to contact Dr. Fitzsimons or our fellowship coordinator, Tina Toland at (617) 643-2286 or ttoland@partners.org for any additional information.

The Massachusetts General Hospital Fellowship Training Program in Cardiac Anesthesia.

NAME: _____

Family

(Maiden)

First

Middle

Present Address:

Permanent Address:

_() _____

_() _____

Correspondence should be mailed to : Present Address ____ Permanent Address: ____

Are you a United States Citizen? Yes__ No__ (If no, complete Section B)

Date of Birth: _____

Have you previously applied to the Massachusetts General Hospital for any appointment:

Yes: __ No __ When: _____ Position: _____

Education:

College/University: _____

Degree: _____ Graduation Date: _____

College/University: _____

Degree: _____ Graduation Date: _____

Medical School: _____

Degree: _____ Graduation Date: _____

Residency: _____

Hospital / University: _____

Completion Date: _____

USMLE part 1 score: _____

USMLE Part 2 score: _____

USMLE Part 3 score: _____

Desired Starting Date: _____

Miscellaneous:

Yes

No

- | | | | |
|----|---|-------|-------|
| a. | Has your professional license in any state ever been revoked, suspended or canceled or otherwise restricted? | _____ | _____ |
| b. | Have you ever been denied professional license in any state? | _____ | _____ |
| c. | Have you ever been request to appear before any professional society or licensing board because of a complaint or charge? | _____ | _____ |
| d. | Have you ever had an action against you by the Narcotics Bureau, or the Treasury Department, or a Federal, State, or Local drug Enforcement agency, or had your DEA permit denied or revoked? | _____ | _____ |
| e. | Has your status as a member of the staff of any hospital, clinic, or other facility, or the scope of your privileges at such facility, Ever been decreases or terminated for any reason? | _____ | _____ |
| f. | Has a mental or physical impairment lasting more than one Month ever interfered with your educational or professional duties within the last years? | _____ | _____ |
| g. | Are you now or have you ever been dependent upon the use of alcohol, stimulants, or other habit-forming drugs? | _____ | _____ |
| h. | Have you ever been convicted of a crime? Do not include a first conviction for drunkenness, simple assault, speeding, minor traffic violation, affray of disturbance of the peace, or conviction of a misdemeanor which occurred more than five years prior to this application if there has been no criminal conviction of any offence with in five years of this application. | _____ | _____ |

IF YOU HAVE ANSWERED “YES” TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A SEPARATE SHEET WITH A DETAILED EXPLANATION.

References:

Please request (3) three letters of recommendation. One letter must be from the program director at your residency training institution.

Name: _____

Position: Program Director _____

Work Address: _____

Name: _____

Position: _____

Work Address: _____

Name: _____

Position: _____

Work Address: _____

I certify that all information in this application is true to the best of my knowledge.

I agree to read and abide by Bylaws, rules, regulations and policies of the professional staff, and or Massachusetts General Hospital.

I agree to undergo a mental or physical examination pursuant to Section 3.02 of the Bylaws if requested and, if this shows evidence of a mental or physical impairment, to provide evidence that the impairment does not interface with my professional competence.

I authorize members of any hospital, or health care facility or professional organization, or any physician or other person with which I have employment, practice, association or privileges, to release to the General Director or the chief of the Service or Department at the Massachusetts General Hospital to which I am applying for appointment or reappointment, or their designees, information regarding my professional skills, any pending or final disciplinary actions * or malpractice information regarding my professional relevant to my character or professional competence, provided such information is given for purposes of credentialing and in good faith without malice.

I authorize my malpractice carrier(s) to release to the General Director or the Chief of the Service or Department of the Massachusetts General Hospital to which I am applying for an appointment or reappointment, or the designees, the following information concerning all malpractice claims or actions for damages pending or closed substance of claim; date and place at which claim arose; amounts paid, if any, and the date and manner of disposition, judgment, settlement or otherwise; and the date and reason for final disposition, if no judgment, or settlement, provided such information is given in good faith and without malice.

I release from civil liability the General Director and the Chief of the Service or Department of the Massachusetts General Hospital in which I have had privileges or to which I am applying for appointment or reappointment, or their designees, the applicable service specific quality professional organization, and any other person authorized by me, who furnishes or reviews information, or who makes recommendations in connection with this application for appointment, provided such makes recommendation are give or performed in good with without malice.

Date _____ Signature of Applicant _____

Section A: TO BE COMPLETED BY NON-U.S. CITIZENS AND FOREIGN MEDICAL GRADUATES

ECFMG Number (attach copy of ECGMG Certificate) _____

Date of VQE _____ Passed _____

Date of FMGEMS _____ Passed _____ Awaiting Notification _____

Are you currently in the United States on a Temporary Visa (i.e. J-1, H-1, F-1)?

No _____ Yes _____ (Attach copy of current I-94 showing expiration date and date first entered the U.S.)

If not currently in the United States, have you been in the United States on a temporary visa within the past five years? No _____ Yes _____ (*complete below)

* Dates (From-To)	Type of Visa	Visa Sponsor
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____
_____ - _____	_____	_____

Do you hold permanent immigration status in the United States? No _____ Yes _____