UC Davis Division of Pain Medicine
SUPPLEMENTAL APPLICATION FOR FELLOWSHIP IN PAIN

GENERAL INSTRUCTIONS: Complete both the Universal Application and the Supplementary Application to apply for a full-time appointment to the University of California, Davis Pain Medicine Fellowship. **In addition to the completed application forwarded by E-mail, please submit a copy of the application with all requested documents from the CHECKLIST on the last page to the Fellowship Director:** Naileshni Singh, M.D.; UC Davis Medical Center; Division of Pain Medicine; 4860 Y Street, Suite 3020; Sacramento, CA 95817. If you have any questions, please call 916-734-6516 OR e-mail PainFellowship@ucdmc.ucdavis.edu. Materials submitted separately must contain the same last name as the application form.

Last Name _____ First_____Middle _____

General Information:

A. We have 6 Fellowship positions available in any given year: Five (5) in August and one (1) in January.
B. Anesthesiologists and non-Anesthesiologists are encouraged to apply.
C. Our program requires a personal interview prior to acceptance.
D. NOTE: Because interviews and acceptances are offered on a rolling-basis, there is no deadline for applying.
E. We may require additional supporting documentation if further clarification about your application is needed.

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 a current ACLS certificate.
   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. How did you hear about the UC Davis Pain Fellowship?

Attending: _____ Another Resident: _____

Internet Website: _____ Other (please describe) _____

II. Fellowship Start Date: August 20___ January20__

III. Current or completed residency:

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

Insert Photo

IV. USMLE or COMLEX Board Score Information (Please remember to have official copies mailed)

	USMLE COMLEX STEP 1	USMLE COMLEX STEP2	USMLE COMLEX STEP3
Score/Percentile			
Number of attempts			
Date of successful completion			

V. Biographical Information

Name _____ Home Telephone _____

Address _____ Cell Telephone _____

City _____ State _____ Zip Code: _____ SSN (last 4 digits) ___ __ ___ ____

Country _____ Email _____

Date of Birth _____ ☐ Male ☐ Female Place of Birth _____
(City, State, Country)

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

A. 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

VI. 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: _____

Last Name _____ **First** _____ **Middle** _____

CHECKLIST (Check each completed item)

Applicant should arrange for the items below to be mailed directly to the Fellowship Director

- ☐ 1. THREE LETTERS OF RECOMMENDATION: Letters must be signed originals sent directly to Dr. Singh. One letter MUST be from either the Rsidency 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.
- ☐ 2. TRANSLATIONS (if applicable): Documents in a language other than English must be accompanied by a certified translation.
- ☐ 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

- ☐ 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.
- ☐ 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.
- ☐ 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.
- ☐ American specialty BOARD CERTIFICATIONS, if applicable. Include (a) American board name, (b) date of certification and (c) date of expiration.
- ☐ If BOARD ELIGIBLE, include (a) American Board name and (b) month/year of certifying examination.
- ☐ 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)
- ☐ DEA registration number, if applicable. Include a Photocopy of certificate.
- ☐ List any pertinent PUBLICATIONS and PRESENTATIONS
- ☐ List any pertinent AWARDS and HONORS
- ☐ List the (a) names, (b) titles, and (c) addresses of 3 references who will be sending letters of recommendation
- ☐ 5. PERSONAL STATEMENT: It should be (a) double-spaced, (b) typed in easily readable 12-point font and (c) should not exceed two pages.
- ☐ 6. PHOTOCOPIES of (a) USMLE, COMLEX, FLEX or NMBE exam scores; and (b) active medical license; and (c) DEA registration certificate.

Last Name _____ **First** _____ **Middle**_____

I. **Acknowledgement and Release Information** Please read the following statements carefully before submitting your application.

I understand that all application material submitted to the University of California becomes the property of the University of California and is *not returnable.*

I understand that the information submitted herein will be relied upon by the University of California to determine my status for interview selection, appointment and training eligibility. I authorize the University of California to verify the information I have provided. I understand that any omission of requested data may jeopardize my admission or subsequent academic standing at the University of California. I agree to notify the Division of Pain Medicine of any changes in the information provided.

I certify that the information in the application and curriculum vitae is *complete and correct to the best of my knowledge and belief. I acknowledge the submission of any false information* is *grounds for rejection of my application, withdrawal of any acceptance offer, appointment revocation, or appropriate disciplinary action after appointment.*

I release from liability and from any restrictions as *to confidentiality or privacy all hospitals,* schools, *physicians, employers, individuals, agencies or organizations that provide information about me at the request of the University of California or its agents.*

I Accept

Last Name _____ First _____ Middle _____