



## FELLOWSHIP IN SURGICAL CRITICAL CARE

Circle start date desired:     2007    2008    2009

- Check track desired:    1 year ACGME approved Surgical Critical Care Fellowship  
                                    1 year post-fellowship acute care surgery  
                                    2 year (ACGME-SCC+ MPH)  
                                    2 year (ACGME-SCC + acute care surgery)  
                                    Unsure

**1. TYPE OR PRINT CLEARLY**

NAME	CITIZENSHIP	SOCIAL SECURITY NUMBER
PRESENT MAILING ADDRESS	DATE OF BIRTH	MARITAL STATUS
	PLACE OF BIRTH	# OF DEPENDENDENTS
TELEPHONE	SEX	MILITARY STATUS
EMAIL ADDRESS	FAX #	PAGER #

**2. EDUCATION – COLLEGE, UNIVERSITIES, AND MEDICAL SCHOOLS**

SCHOOL AND ADDRESS	YEARS (FROM – TO)	DEGREE

**UT SOUTHWESTERN FELLOWSHIP IN SURGICAL CRITICAL CARE**

**Application** (PAGE THREE)

**NAME:** \_\_\_\_\_

**HOSPITALS WHERE INTERNSHIP, RESIDENCY, FELLOWSHIP TAKEN** (*indicate which*)

HOSPITAL	SPECIALTY	YEARS (FROM – TO)	PROGRAM DIRECTOR

*If breaks occurred during education, training, and the present, please account for time on separate sheet.*

**LIST OF HONORS, AWARDS AND PUBLICATIONS** (*use separate sheet if necessary*)


**3. REFERENCES: LIST THREE NAMES, TITLES, ADDRESSES AND PHONE NUMBERS**


**4. STATE YOUR GOALS IN CRITICAL CARE**

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**5. Board Eligible / Certified in** (*please circle*) \_\_\_\_\_

**6. Licenses to practice in state(s) of** \_\_\_\_\_

photo (optional) 2 ½ x 2 ½
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**Application (PAGE THREE)**

**NAME:** \_\_\_\_\_

**7. PROFESSIONAL LIABILITY**

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?  
\_\_\_\_ Yes                      \_\_\_\_ No                      If yes, please provide list and status on a separate sheet

**8. DISCIPLINARY ACTIONS**

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, placed on probation, not renewed or voluntarily relinquished? If yes, provide full explanation on a separate sheet.

- Medical license in any state.....Yes \_\_\_ No \_\_\_
- Other professional registration/license.....Yes \_\_\_ No \_\_\_
- DEA registration.....Yes \_\_\_ No \_\_\_
- Academic appointment.....Yes \_\_\_ No \_\_\_
- Membership on any hospital medical staff .....Yes \_\_\_ No \_\_\_
- Clinical privileges .....Yes \_\_\_ No \_\_\_
- Prerogative/rights on any medical staff .....Yes \_\_\_ No \_\_\_
- Other institutional affiliation or status threat .....Yes \_\_\_ No \_\_\_
- Professional society membership or fellowship/Board certification .....Yes \_\_\_ No \_\_\_
- Professional office .....Yes \_\_\_ No \_\_\_
- Any other type of professional sanction .....Yes \_\_\_ No \_\_\_
- Professional liability insurance .....Yes \_\_\_ No \_\_\_
- Have there been any felony criminal charges brought against you in the last five years .....Yes \_\_\_ No \_\_\_
- Have you been convicted of any crimes .....Yes \_\_\_ No \_\_\_

**9. HEALTH STATUS**

(If any of these questions are answered in the affirmative, please provide full explanation on a separate sheet.)

Do you presently have a physical or mental health condition, including Alcohol or drug dependence, that affects or is reasonable likely to affect your ability to perform professional or medical duties appropriately?                      Yes \_\_\_                      No \_\_\_

Are you currently under care for a continuing health problem?                      Yes \_\_\_                      No \_\_\_

Have you at any time during the last five years been hospitalized Or received any other type of institutional care for a health problem?                      Yes \_\_\_                      No \_\_\_

Comments:

**10. SIGNATURE**

I hereby certify that to the best of my knowledge and belief, I have no physical or mental illness or mental defect which interferes with my professional appointment. All information submitted by me in this application is true and accurate to my best knowledge and belief.  
**(Please enclose a photo (optional)).**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**11. PLEASE FORWARD THIS FORM, YOUR CV AND THREE LETTERS OF RECOMMENDATION TO:**

Heidi Frankel, M.D.  
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Department of Surgery  
UT Southwestern Medical Center  
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Dallas, TX 75390-9158  
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