



Parkland
Health & Hospital System

FELLOWSHIP IN SURGICAL CRITICAL CARE

Circle start date desired: 2010 2011 2012

- 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

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

6. Licenses to practice in state(s) of _____

photo (optional) 2 ½ x 2 ½

UT SOUTHWESTERN FELLOWSHIP IN SURGICAL CRITICAL CARE

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 staffYes ___ No ___
- Clinical privilegesYes ___ No ___
- Prerogative/rights on any medical staffYes ___ No ___
- Other institutional affiliation or status threatYes ___ No ___
- Professional society membership or fellowship/Board certificationYes ___ No ___
- Professional officeYes ___ No ___
- Any other type of professional sanctionYes ___ No ___
- Professional liability insuranceYes ___ No ___
- Have there been any felony criminal charges brought against you in the last five yearsYes ___ No ___
- Have you been convicted of any crimesYes ___ 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.
Program Director, Surgical Critical Care Fellowship
Department of Surgery
UT Southwestern Medical Center
5323 Harry Hines Blvd. E5.514
Dallas, TX 75390-9158
Phone: 214-648-5469 Fax: 214-648-2213