

UCSF FRESNO APPLICATION FOR CRITICAL CARE/TRAUMA FELLOWSHIP

Available to begin _____

(date)

Type or Print (black ink is preferred)

1. Name (Last) (First) (Middle) 2. Social Security No.

3. Address (Street) (City) (State) (Zip Code)

4. Phone Number Day () Evening () Email _____

5. Date of Birth: _____ 6. Citizenship
Place of Birth: _____ [] USA
[] Other _____

7. Visa Status (if applicable)
[] Permanent [] J-1
[] Temporary

8. Institution(s) of General Surgery Training	Specialty	Dates
Year	(If other than general surgery)	(from - to)
1 st		
2 nd		
3 rd		
4 th		
5 th		
6 th		

Additional:

9. California License [] Yes Number _____
[] No

Attach Recent

10. License - Other States _____

State License number

Photo

Send application to: Krista L. Kaups, M.D.
Critical Care/Trauma Fellowship Director
Community Regional Medical Center
2823 Fresno St., Dept. Surgery 1st Fl
Fresno, CA 93721

11. I have taken and passed the following exams: _____ American Board of Surgery
 USMLE Part I (Score) _____ Part I
 USMLE Part II (Score) _____ Part II
 USMLE Part III (Score) _____ Eligible to take Exam

12. Medical School(s)
 (Name) (City) (State) (Degrees) (Year)

13. Colleges(s)
 (Name) (City) (State) (Degrees) (Year)

14. High School
 (Name) (City) (State) (Degrees) (Year)

15. Reference

A. (Name) (Title) (Institution)

(Address)

B. (Name) (Title) (Institution)

(Address)

C. (Name) (Title) (Institution)

(Address)

(CHECK ONE)

I hereby waive access to the above letters and will so inform the authors.

I desire access to the above letters and will so inform the authors.

 Signature

 Date

Note: The Signature and Date on this statement Must be Original