Obstetric Anesthesiology

The Department of Anesthesiology at Stanford University Medical Center offers 3, one-year, ACGME-accredited fellowships in Obstetrical Anesthesia. The Obstetric Anesthesiology Fellowship combines advanced clinical training with the opportunity to engage in research and education. The fellowship equips its graduates for a variety of careers, including academic or private practice, with the ability to act as a consultant in obstetric anesthesiology.

The Obstetric Anesthesia fellowship programs in the United States have agreed to participate in a Match by the San Francisco Matching Program (SF Match). You are required to apply through the SF Match in addition to submitting your application materials to our program.

Timeline for the SF Match:

January 10, 2022	Application registration begins for SF Match
May 20, 2022	Deadline for Stanford Obstetric Anesthesia Application Materials
June 14, 2022	Rank list deadline, 12:00 PM PST
June 21, 2022	Match results are released

Application Review Process and Interview Schedule:
Applications will be reviewed as they come in. All materials (including LORs) will need to be submitted and received in order for applications to be reviewed.

Please send your completed Obstetric Anesthesia application and materials to:
Alyssa Martinez, Fellowship Coordinator
amart10@stanford.edu
(650) 497-2640
Department of Anesthesiology, Perioperative and Pain Medicine
Stanford University School of Medicine
300 Pasteur Drive, H3583
Stanford, CA 94305-5640

We strongly encourage applicants to email all application materials and will not accept photos taken of documents. To ensure completion of your application, it is best if your letter writers email your recommendation letters directly to Alyssa Martinez, but continue to write/address the letter to Dr. Traynor.

Interviews are tentatively scheduled for February, April and June 2020.

Obstetric Anesthesia Fellowship applicants are asked to submit the following items:

1. Application
2. Personal Statement
3. Curriculum Vitae
4. Three original letters of recommendation

If you are accepted into the Obstetric Anesthesia fellowship program, you will be required to submit the following items:

1. Professional photo
2. Copy of medical school diploma
3. Copies of USMLE scores – originals not required

For further details, you can also review the Obstetric Anesthesiology Website.

Stanford MEDICINE | Department of Anesthesiology, Perioperative and Pain Medicine

APPLICATION FOR OBSTETRICAL ANESTHESIOLOGY (OB) FELLOWSHIP
(Please type or print)

Date of Application _____

Name _____ Social Sec. No. _____
(Last) (First) (Middle)

Date Fellowship to Begin ☐ July 1 ☐ August 1 Canadian SIN: _____

Present Address: _____
(Street) (City) (State) (Zip) (Country if other than USA)

Permanent Address: _____
c/o (Name) (Street) (City) (State) (Zip) (Country if other than USA)

Present Telephone: _____ Permanent Telephone: _____ E-Mail Address: _____

Date of Birth: _____ Birth Place: _____ Gender: ☐ Male ☐ Female

UNDERGRADUATE EDUCATION (List in chronological order)

Name of School	City/State/Country	Inclusive Dates (Mo/Day/Yr) From To	Degree/Date (Mo/Day/Yr)

GRADUATE AND/OR MEDICAL EDUCATION (List in chronological order)

Name of School	City/State/Country	Inclusive Dates (Mo/Day/Yr) From To	Degree/Date (Mo/Day/Yr)

PREVIOUS POSTGRADUATE RESIDENCY AND/OR FELLOWSHIP TRAINING

Postgraduate Year 1 _____
Specialty (Mo/Day/Yr) to (Mo/Day/Yr)
_____
Institution Name City/State/County

Postgraduate Year 2 _____
Specialty (Mo/Day/Yr) to (Mo/Day/Yr)
_____
Institution Name City/State/County

Postgraduate Year 3 _____
Specialty (Mo/Day/Yr) to (Mo/Day/Yr)
_____
Institution Name City/State/County

Postgraduate Year 4 _____
Specialty (Mo/Day/Yr) to (Mo/Day/Yr)
_____
Institution Name City/State/County

Other: _____

Specialty (Mo/Day/Yr) to (Mo/Day/Yr)

_____

Institution Name City/State/County

WORK EXPERIENCE OR OTHER EDUCATIONAL/RESEARCH EXPERIENCE SINCE MEDICAL SCHOOL GRADUATION

Position Institution/Organization Location Inclusive Dates

_____

_____

_____

Honors: _____

_____

Extracurricular Activities: _____

_____

USMLE ID: _____ **(Required for USMLE transcript transmission)**

NBOME ID: _____ **(Required for COMPLEX transcript transmission)**

United States Medical Licensing Examination (USMLE) OR Comprehensive Medical Licensing Exams (COMLEX) Circle One

Step/Level 1 _____ _____ _____ Passed: _____Yes _____No # Attempts*: _____
Date Taken Score Percentile

Step/Level 2 _____ _____ _____ Passed: _____Yes _____No # Attempts*: _____
Date Taken Score Percentile

Step/Level 3 _____ _____ _____ Passed: _____Yes _____No # Attempts*: _____
Date Taken Score Percentile

IN-Training Exam (ITE): **Score given by the ABA for those who have completed or are in the process of completing an anesthesia residency. Provide National Percentile.**

Score# 1 _____ Score#2 _____ Score#3 _____

National Provider Number (NPI) _____

PROFESSIONAL LICENSURE (list any medical licenses issued including unrestricted license, training permits, certificates of registration, etc.)

State License Number Type Date Issued Expiration Date

Medical License: _____

_____

_____

DEA Number: _____

Other (specify): _____

INFORMATION REQUIRED OF NON-U.S. CITIZENS AND GRADUATES OF NON-LCME ACCREDITED MEDICAL SCHOOLS

Visa Type and Status (Attach copy of Visa): Type _____ Date Issued _____ Expiration Date _____

ECFMG Step 1: Date Taken _____ Score _____ Step 2: Date Taken _____ Score _____

TOEFL Exam: Date Taken _____ Score _____ CSA Exam: Date Taken _____ Score _____

ECFMG Certificate No. _____ Date Issued _____ Expiration Date _____

MILITARY SERVICE - List Status (Active/Inactive), Rank, Branch, Inclusive Dates, Type Discharge, if applicable:

Are you committed to fulfill U.S. military active duty service obligations/deferments?

☐ Yes ☐ No

If yes, date of anticipated fulfillment of obligation: _____

Military Branch: _____

Do you have any other service obligations? (i.e. Military Reserves or Public Health/State programs)

☐ Yes ☐ No

Description:

MISCELLANEOUS:

Has your medical license ever been suspended/revoked/voluntarily terminated?

☐ Yes ☐ No

Reason:

Have you ever been named in a malpractice case?

☐ Yes ☐ No

Reason:

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?

☐ Yes ☐ No

Reason:

Have you ever been convicted of a felony?

☐ Yes ☐ No
Reason:

PHOTO

Signature of Applicant (sign in ink) **Date**