

UNIVERSITY OF ALABAMA AT BIRMINGHAM

DEPARTMENT OF MEDICINE DIVISION OF NEPHROLOGY

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APPLICATION FOR INTERVENTIONAL NEPHROLOGY FELLOWSHIP

YEAR APPLYING FOR _____ Date of Application _____

Name (Last, First, Middle, no initials) _____
_____ Maiden Name _____ (if applicable)

Social Security Number _____

Office _____ Address _____

_____ Fax _____ #

_____ Telephone _____ E-mail Address: _____

Home Address _____

E-mail Address: _____ Telephone _____

Citizen of _____ (if not U.S. Citizen complete Page 3, Non-US Citizens And Graduates section)

Sociodemographic Data:

Place of Birth _____ Date of Birth _____

City/State/Country

Race _____ Marital Status _____ No. of Children _____

Name of Spouse _____
(if applicable) (Last) (First) (Middle)

Nearest Relative _____ Phone # _____

and Address _____

UNDERGRADUATE EDUCATION (list in chronological order)

Name of School	City/State/Country	Date		Degree
		From	To	

MEDICAL SCHOOL

(If Medical School is not LCME accredited complete Page 3 Non-LCME portion)

Name of School	City/State/Country	Date		Degree
		From	To	

USMLE:

Step I _____ / _____ Step II _____ / _____ Step III _____ / _____
(date taken) (score) (date taken) (score) (date taken) (score)

INTERNAL MEDICINE BOARDS: _____ (date taken)

VERIFICATION OF NEPHROLOGY FELLOWSHIP: (Attach letter from program director or copy of certificate)_

RESIDENCIES/FELLOWSHIPS

1st Year Postgraduate _____
Specialty _____ (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

2nd Year Postgraduate _____
Specialty _____ (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

3rd Year Postgraduate _____
Specialty _____ (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

Fellowship _____
Specialty _____ (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

Other Postgraduate Training _____
Specialty _____ (Mo/Yr) to (Mo/Yr)
Institution Name: _____ City/State _____

RECOMMENDATION: List those asked to write letters of recommendation. (Please have letters sent directly to Dr. Maya. Please include name, address and position below)

(1) _____

(2) _____

(3) _____

LICENSURE

<u>Description</u>	<u>State</u>	<u>Number</u>	<u>Date of Issue</u>	<u>Expires</u>
Medical//Dental License: _____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
DEA Number: _____	_____	_____	_____	_____
Other (specify): _____	_____	_____	_____	_____

PREVIOUS EDUCATIONAL OR RESEARCH EXPERIENCE, INCLUDING PUBLICATIONS:

Honors: _____

Extracurricular Activities: _____

Military Service: _____ by a court-martial? _____

(Nature of your discharge _____)

Health Status: Number of days lost last year due to illness _____ Nature of Illness _____

*Do you now abuse chemical substances, as defined herein? Yes ___ No ___

Have you ever been convicted of any charge(s) related to or pertaining to chemical substance abuse, or the possession, sale or distribution of illegal or legally controlled substances? Yes ___ No ___

*(Substance abuse is defined as using drugs for non-medical reasons in an attempt to influence the mind and body, to alter emotions and senses, and to escape reality. A drug can be considered as any substance, other than food and including alcohol, that has an effect on the central nervous system or other systems of the body.)

Other Charges and Violations:

Are you now under charges for any violation of law or have you ever been convicted of or forfeited collateral for any violation of law punishable by imprisonment of longer than one year, *except for:*

traffic fines of \$100 or less; any offense committed before your 18th birthday adjudicated in a juvenile court or under a youth offender law; any conviction for which the record has been expunged under federal or state? .Yes No

Is there any malpractice action or claim pending against you?Yes No

Has there ever been a malpractice judgment against you or a monetary settlement of a claim against you?Yes No

Have you ever been refused medical licensure? Yes No

Has your medical license ever been suspended or revoked? Yes No

If you answered "Yes" to any of the above, give details. For each, give (1) date, (2) charge, (3) place, (4) court, (5) action taken. (Use additional sheets if necessary.) _____

INFORMATION REQUIRED OF NON-US CITIZENS AND GRADUATES FROM NON-LCME SCHOOLS

Visa Type and Status Type _____ Expiration date _____
(attach copy of VISA)

ECFMG Certificate No. _____ Date Issued _____ Valid Through _____
(attach copy of certificate)

FMGEMS: _____ Part I _____ Part II _____
(Date taken) (Score) (Score)

Flex Examination _____ / _____
(Date taken) (Score)

ECFMG: _____ / _____
(Date taken) (Score)

I CERTIFY that the answers to the foregoing questions are true and complete to the best of my knowledge and belief, and are made in good faith. I give UAB the right to contact all persons (organizations) named to gain information relevant to this application. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute sufficient grounds to UAB to terminate my fellowship without notice. I acknowledge by my signature that I have read and understand these statements.

Signature of Applicant (sign in ink)
Mailing Address:
Roman Shingarev, MD
Associate Professor of Medicine and Radiology
University of Alabama at Birmingham
1720 2nd Ave South, ZRB 624
Birmingham, AL 35294-0007

Date
Physical Address:
UAB, Nephrology
1900 University Blvd, THH 643
Birmingham, AL 35249-0007

Phone # (205) 934-1801; Fax # (205) 934-7742 (attention: Jessica Hargrove)