

Clinical Cardiac Electrophysiology Fellowship Training Program

The CCEP fellowship is a 2 year ACGME accredited program that accepts one fellow who has successfully completed an ACGME accredited cardiology fellowship. A valid California medical license is required. Applications are accepted now for July 1, 2020 start date.

Application Instructions

Please complete attached application. Along with the completed application, the following documentation is also required.

- Personal statement
- Three letters of recommendation, one from your current program director
- Copy of ECFMG Certificate (If applicable)
- Certificate of completion of an ACGME accredited cardiovascular fellowship
- Copy of DL or State issued Identification

Application will not be considered if all required documentation not received before cut-off date of January 15. **Mail** completed application along with required documents to: UCD HEALTH-CCEP Training Program, 4860 Y Street, Ste. 2820, Sacramento, CA 95817. Application and documents can also be sent by **email** to ctcuellar@ucdavis.edu.

Contact information is listed below, do not hesitate to contact us directly if you would like additional information about the training program or if you have any questions about the application process. Thank you for choosing the University of California, Davis and look forward to further correspondence with you.

Program Director

Dr. Uma Srivatsa
unsrivatsa@ucdavis.edu

University of California, Davis
Cardiovascular Medicine
4860 Y Street, Ste. 2820
Sacramento, CA 95817

Fellowship Coordinator

Catherine Cuellar
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UC DAVIS HEALTH
DIVISION OF CARDIOVASCULAR MEDICINE
4860 Y STREET, SUITE 2820
SACRAMENTO, CA 95817
Phone (916) 734-3764
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SCHOOL OF MEDICINE

APPLICATION FOR POSTGRADUATE ELECTROPHYSIOLOGY FELLOWSHIP

- 1. Name:
2. Desired Starting Date:
3. Address:
Phone Number:
Pager:
Email Address:

Table with 3 columns: State, License number, Valid through (MM/YY). Rows a and b.

5. Has your medical license ever been suspended, revoked, or involuntarily terminated? YES [] NO []
If yes, please explain:

6. Are you board certified? YES [] NO []
Board Name

7. E.C.F.M.G. Certification (for graduates of other than U.S. or Canadian medical schools only)
Certificate Number: Expiration date:

8. If you are not a citizen of the United States, do you have the legal right to remain and work in the U.S.?
YES [] NO [] NOT APPLICABLE []
Visa Status: Permanent Resident [] J-1 []

9. Have you ever been named in a malpractice case? YES NO

If yes, please explain:

10. Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges? YES NO

If yes, please explain:

11. Have you ever been convicted of a felony? YES NO

If yes, please explain:

12. College and Address:

Dates of Attendance:

Degree Obtained:

Date of Graduation:

13. Medical School and Address:

Dates of Attendance:

Degree Obtained:

Date of Graduation:

14. Internship (institution and address):

Date of Attendance:

Specialty:

15. Residency (institution and address):

Dates of attendance:

Specialty:

Date of Graduation:

16. Additional postgraduate training:

Dates of attendance:

Specialty:

Date of Graduation:

17. Private practice of medicine (location and dates), if applicable:

18. Honors and awards received (give details):

19. Research Experience (including publications)

20. Membership in professional societies (You may exclude any societies which would indicate race, religion, sex, marital status, age, color, national origin or physical handicap)

21. Why do you want to go into the field of electrophysiology?

22. How important do you perceive research training to be in terms of your career objectives?

23. What would you like to do immediately after your fellowship training period?

CHARACTER REFERENCES (from whom letters of recommendation (LOR) may be expected):

LORs from 2 supervising faculty members and current program director only

24. Name: _____ Institution: _____
Position or Title: _____ Address: _____
Phone Number: _____
Number of Years Known to Applicant: _____

25. Name: _____ Institution: _____
Position or Title: _____ Address: _____
Phone Number: _____
Number of Years Known to Applicant: _____

26. Name: _____ Institution: _____
Position or Title: _____ Address: _____
Phone Number: _____
Number of Years Known to Applicant: _____

LIST OF REQUIRED ATTACHMENTS:

- A) Personal Statement
- B) Current Curriculum Vitae
- C) Copy of ECFMG Certificate (if applicable)
- D) Three letters of recommendation
- E) Copy of your current medical license
- F) Copy of valid identification card

APPLICANT SIGNATURE

Name

Date: