



DEPARTMENT OF NEUROSURGERY,
UNIVERSITY OF PITTSBURGH APPLICATION FOR FELLOWSHIP

IONM NON-ACGME

Name:

Email:

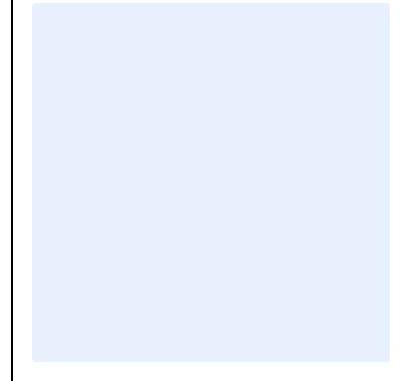
Phone:

Address:

Citizenship:

Birthdate:

Picture:



Residency training:

Neurology Pediatric Neurology

Board certified (Year):

Board Eligible (Year):

Subspecialty Training:

Specify:

Board certified (Year):

Board Eligible (Year):



EDUCATION AND TRAINING:

Premedical:

Institution:

Years:

Degrees Earned:

Medical School:

Institution:

Internship (PGY1):

Type:

Institution:

Years:

Program Director:

Residency:

Type:

Institution:

Years:

Program Director:

Fellowship:

Type:

Institution:

Years:

Program Director:

Other graduate training:

- 1.
- 2.
- 3.



Research Experience:

- 1.
- 2.
- 3.
- 4.
- 5.

Honors:

- 1.
- 2.
- 3.

Publications: (attach an extra sheet if more space is needed):

- 1.
- 2.
- 3.
- 4.
- 5.

Abstracts at National Meetings:

- 1.
- 2.
- 3.
- 4.
- 5.

Hobbies/Interests, other activities:



License Information as Applicable:

Current State Medical Licenses (List and **attach copies of all** unrestricted licenses):

1. State:

License Number:

Expiration Date:

2. State:

License Number:

Expiration Date:

3. DEA Number:

State:

Expiration Date:

NBME: Date Part III of Exam taken and passed:

(Attach copies of Parts I, II, III)

**EXAMINATIONS:**

USMLE (Indicate dates taken):

Step 1:

Step 2:

Step 3:

(indicate successful completion attempt/ score):

Step 1:

Step 2:

Step 3:

(ATTACH copies of scores from Step 1, 2 and 3)

Has your state license or application for state license
Ever been denied, suspended or revoked?

Yes No

Has your membership on a hospital's medical staff
Ever been denied, revoked or suspended?

Yes No

Have you ever had your State or Federal Controlled
Substance License (DEA) revoked, suspended or denied?

Yes No

Have you ever been convicted of a felony?

Yes No

Have you ever been found guilty of malpractice or
Negligence?

Yes No

If your answer to any of the above questions is affirmative, please attach a letter of
Clarification.



Please list persons from whom you are requesting letters of evaluation. Include the Director of your most recent training program and have the letters sent directly to the address below.

Name

Position/ Contact email and phone #

1.

2.

How did you learn of this program?

Alumni (Name)

AAN

AES

ACNS

FREIDA

UPMC Website

Other (Please Explain)

Signature of Applicant

Date:

List of Required documents:

- Completed application
- Current CV
- Medical school transcript
- 2 Letters of reference (including one from current program director)
- Board Certification or In-Training Examination scores
- Results of USMLE / COMLEX Exam Reports
- Copy of state medical license if applicable

Completed applications should be sent to:

Katherine M. Anetakis, MD

Assistant Professor, Neurological Surgery

Attending of Clinical Neurophysiology

Katherine.Anetakis@chp.edu

Subject Line Should Read: Fellowship Application 2024-25