

**MultiCare**  **Tacoma Family Medicine**  
**OBSTETRICS FELLOWSHIP**  
**TACOMA, WASHINGTON**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(City)

(State)

(Zip)

Work Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(City)

(State)

(Zip)

Email Address: \_\_\_\_\_

**Board Certification**

- ABFM                      Year certified \_\_\_\_\_      Year renewed \_\_\_\_\_
- Other                        Year certified \_\_\_\_\_      Year renewed \_\_\_\_\_
- Board eligible

**List all active licenses**

State	License number	Expiration date
DEA Certificate	Certificate number	Expiration date

**Certifications held and expiration date**

BLS \_\_\_\_\_  ACLS \_\_\_\_\_  ATLS \_\_\_\_\_  PALS \_\_\_\_\_

NRP \_\_\_\_\_  ALSO \_\_\_\_\_  Other \_\_\_\_\_  N/A

**Medical Education**

School of Graduation Degree Dates

Internship Type Dates

Residency Specialty Dates

Fellowship Specialty Dates

**Professional Experience (if applicable)**

Name/Type of Practice Dates

City State Zip Position

Name/Type of Practice Dates

City State Zip Position

**Hospital Privileges**

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Name of Hospital	Street Address	City	State	Zip
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Name of Hospital	Street Address	City	State	Zip
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What year are you interested in applying for? \_\_\_\_\_

Please provide a **copy** of your

- **Medical School Diploma/Transcripts**
- **ABFM Board Certification** (not applicable if still in Family Medicine Residency)
- **Residency Certificate** (not applicable if still in Family Medicine Residency)



**5b) If you are in practice, what is compelling you to leave your practice for year and spend it with us?**

**6. After completing the fellowship, where do you anticipate practicing and what type of practice do you see yourself in? (please be as specific as possible).**

**7. Please describe past experiences teaching residents and/or medical students.**

**Please enclose current curriculum vitae and provide us with Letters of Recommendation from Residency Program Director and two other references.**

**REFERENCES:**

Name/Title	Institution	Address	Phone

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please submit materials to:

Jean Basaraba, Fellowship Coordinator

[tacomafmobfellowship@multicare.org](mailto:tacomafmobfellowship@multicare.org)