AMERICAN COLLEGE OF GASTROENTEROLOGY

6400 Goldsboro Road, Suite 200, Bethesda, Maryland 20817-5842
Telephone: 301-263-9000, Fax: 301-263-9025

ADVANCEMENT TO FELLOWSHIP APPLICATION

QUALIFICATIONS FOR ADVANCEMENT TO FELLOWSHIP

- Fellowship is an honor bestowed by the American College of Gastroenterology in recognition of significant professional achievement and superior competence within the field of gastroenterology, pediatric gastroenterology, gastrointestinal surgery, gastrointestinal radiology, or gastrointestinal pathology.
- Letters of recommendation by two Fellows of the College.
- Current uninterrupted membership or international membership in the College for a period of no less than three years. During this time demonstration of scholarly activities, which include continuing education experience, professional leadership and excellence in the fields of clinical practice and/or academic medicine.
- An individual wishing to advance to Fellowship should successfully complete a minimum of 3 CME programs sponsored by the ACG within the last six years and provide evidence of involvement in ACG activities such as Committees, etc.
- Documentation of certification by one or more of the following specialty boards recognized by the Council on Graduate Medical Education of the American Medical Association: American Board of Internal Medicine, (subspecialty Boards in Gastroenterology), or its equivalent, e.g. American Board of Pediatrics (subspecialty Board in Gastroenterology), American Board of Surgery, American Board of Radiology, American Board of Pathology, American Osteopathic Board of Internal Medicine.
- For more information on Membership qualifications, visit us online at gi.org.

CONTACT INFORMATION *(Copy of CV must be attached)*

First Name: ______________________ Middle Initial: ________ Last Name: ______________________

Date of Birth (mm/dd/yyyy): ______________ NPI Number *(required for U.S. physicians only)*: ______________________

Office Address:____

City:______________ State: __________ Zip/Postal Code: __________ Country:______________

E-mail:____

Phone *(Int'l include country and city codes for all numbers)*: ______________________ Fax: ______________

Home Address:____

City:______________ State: __________ Zip/Postal Code: __________ Country:______________

Home Phone: ______________________

Please mail materials to my: ☐ Office Address ☐ Home Address

EDUCATION

University:______________________ Degree: ______________ Date Awarded: __________

Medical School: ______________________ Degree: ______________ Date Awarded: __________

POSTGRADUATE TRAINING

Internship: ______________ Institution:______________________ Inclusive Dates: __________

Residency:______________ Institution:______________________ Inclusive Dates: __________

Fellowship: ______________ Institution:______________________ Inclusive Dates: __________

Other: ______________ Institution:______________________ Inclusive Dates: __________

MEDICAL LICENSURE / BOARD CERTIFICATIONS *(copies of the board certificates must be attached)*

Name on Medical License: ______________________ State / Country: ______________ Registry #: __________

Specialty Board: ______________________ Certificate #: ______________ Date: __________

Sub-Specialty Board: ______________________ Certificate #: ______________ Date: __________

HOSPITAL APPOINTMENTS *(begin with current)*

Hospital: ______________________ Position: ______________ Inclusive Dates: __________

Hospital: ______________________ Position: ______________ Inclusive Dates: __________

Hospital: ______________________ Position: ______________ Inclusive Dates: __________

Hospital: ______________________ Position: ______________ Inclusive Dates: __________

TEACHING AFFILIATIONS *(begin with current)*

I currently teach: ❑ Full-time ❑ Part-time Hours per week: ______

I ❑ am ❑ am not at present engaged in private practice in addition to my present teaching duties.

Institution: ______________________ Position: ______________ From: ______ To: ______

Institution: ______________________ Position: ______________ From: ______ To: ______

Institution: ______________________ Position: ______________ From: ______ To: ______

Institution: ______________________ Position: ______________ From: ______ To: ______

RESEARCH & PUBLICATIONS

Please attach separately.

CONTINUING MEDICAL EDUCATION

In support of my application for Advancement, I submit the following information and enclose certificate(s) of attendance.
I have taken the following Postgraduate Courses in Gastroenterology:

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

Title of Course: ______________________ Sponsor: ______________ Date: ______ Hours: ____

I have attended the following Annual Scientific Meetings of the ACG:

Year: ______ Year: ______ Year: ______ Year: ______ Year: ______ Year:______ Year: ______

DEMOGRAPHICS / PRACTICE SETTING *(Optional)*

1. Gender: ❑ Male ❑ Female

2. Practice Setting: *(check all that apply)*

- ❑ Private Practice:
  - ❑ Solo Practice
  - ❑ Practice with 5 or fewer physicians
  - ❑ Practice with 6 - 10 physicians
  - ❑ Practice with 11 or more physicians
  - ❑ Multi-specialty group
- ❑ Academic:
  - ❑ Pure Clinician
  - ❑ Clinical Educator
  - ❑ Basic Science Researcher
- ❑ Non-Practice Setting / Other

3. Is your GI practice: ❑ Independently Owned GI Practice ❑ Health System/Hospital Affiliated or Owned GI Practice

4. Do you or your practice own all or part of an ASC? ❑ Yes ❑ No **If Yes,** is the ASC: ❑ Single Specialty GI ❑ Multi-specialty
If Yes, which endowriter software do you use in your ASC?________________________

5. Does your practice employ NPs or PAs? ❑ Yes ❑ No **If Yes,** how many? NPs:________ PAs:________

6. Do you participate in Clinical Research? ❑ Yes ❑ No **If Yes**, what % of your time is protected for clinical research? ______**%**

7. Do you treat pediatric patients? ❑ Yes ❑ No

8. Are you practicing full-time or part-time: ❑ Full-time ❑ Part-time

9. Which EMR or EHR software do you use in your practice? ____________________________________

10. What % of your time each week is spent doing the following: _____ % Colonoscopy _____ % EGD _____ % Other Procedures _____ % Eval/Mgmt

11. Do you or your practice own the following ancillary services (*check all that apply*)**:** ❑ Pathology ❑ Infusion ❑ Anesthesia

12. Areas of Interest / Specialty: *(check all that apply)*

❑ Biliary	❑ Colon	❑ Endoscopy	❑ Esophagus	❑ Functional	❑ General GI
❑ Geriatrics	❑ IBD	❑ Liver / Hepatology	❑ Motility	❑ Oncology	❑ Outcomes Studies
❑ Pancreas	❑ Pediatrics	❑ Small Bowel	❑ Stomach		

13. Other than English, what language(s) are spoken in your office: *(check all that apply)*

❑ Arabic	❑ Cantonese	❑ Farsi	❑ French	❑ Hebrew	❑ Mandarin
❑ Portugese	❑ Spanish	❑ Vietnamese	❑ Other Language: ____________________		

14. Are you a member of the Armed or Uniformed Services? ❑Yes ❑ No

LETTERS OF RECOMMENDATION BY TWO FELLOWS OF THE COLLEGE

Two Fellows of the College will both need to send a letter supporting your application. You may attach the letters to your application or they can be mailed separately to the ACG. If you need assistance finding a Fellow, please send an e-mail to info@gi.org.

Name: ______________________________ Phone: ______________________ E-mail :______________________________

Name: ______________________________ Phone: ______________________ E-mail :______________________________

Signature of Applicant:____

PAYMENT INFORMATION

Application Fee: $50 *(Payment must be submitted with application in U.S. Dollars only)*

❑ My check made payable to the ACG is enclosed.

Credit Card: ❑ Visa ❑ Mastercard ❑ American Express

Credit Card Number:______________________________ Exp. Date: _______________ 3 or 4 Digit Security Code: ________________

Name on card:______________________________ Signature: ______________________________

This section for use by ACG Governors only.

Action by Governor: ❑ Approved ❑ Not-Approved

Signature of Governor: ______________________________

Governor's Comments: ______________________________

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