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.
- Proposal and endorsement 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 *(Please attach a copy of your CV.)*

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ 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: _____

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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: _____

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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 *(Optional)*

Gender: ❑ Male ❑ Female

Research: Do you participate in Clinical Research? ❑ Yes ❑ No
Do you participate in Basic Research? ❑ Yes ❑ No

Practice Setting: *(check all that apply)*

❑ Private Practice**:**
- ❑ Solo Practice
- ❑ Practice with 5 or fewer MDs
- ❑ Practice with 6 or more MDs
- ❑ Multi-specialty group

❑ Academic**:**
- ❑ Pure Clinician
- ❑ Clinical Educator
- ❑ Basic Science Researcher

❑ Non-Practice Setting / Other

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

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

PROPOSER INFORMATION

Please attach a letter of support from your proposer. If you need assistance finding a proposer, please send an e-mail to info@gi.org.

Proposer's Name (Must be an ACG Fellow)**:** _____

Proposer's Phone Number: _____ E-mail Address: _____

ENDORSER INFORMATION

Please attach a letter of support from your endorser. If you need assistance finding an endorser, please send an e-mail to info@gi.org.

Endorser's Name (Must be an ACG Fellow)**:** _____

Endorser's Phone Number: _____ E-mail Address: _____

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. ❑ My credit card information is below.

❑ 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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