



THE UCLA SPINE CENTER PHYSICAL MEDICINE AND REHABILITATION SPINE MEDICINE TRAINING PROGRAM

The UCLA Spine Center PMR Spine Medicine Fellowship is designed to train physicians with an emphasis on an interdisciplinary approach to spinal disorders and their management. Each fellow completing the Spine Medicine Fellowship will have worked alongside a multidisciplinary team that includes Physiatrists, Anesthesiologists, Neurologists, Pediatricians, Psychiatrists, Neurosurgeons, Orthopedic Spine Surgeons, Physical Therapists, and Psychologists in obtaining expertise in Spine Medicine. This will include the prescription of physical therapy/modalities, use of opioid and adjuvant medications, electrodiagnostic medicine, and bracing. Substantial training in interventional spine procedures at all spinal levels and minor surgical procedures (Kyphoplasty, Vertebroplasty, and Spinal Cord and Peripheral Stimulators) will also be emphasized. In addition to general musculoskeletal and spine disorders, there will be exposure to cervicogenic headaches, facial pain, cancer pain, vertebral compression fractures, and scoliosis. The spine fellow will also be responsible for the coordination of patient care between various services and assist in the education of PM&R residents and medical students from the David Geffen School of Medicine at UCLA.

The goals and objectives of the Spine Management Fellow are:

1. To gain the fundamental knowledge base required for the practice of comprehensive Spine Medicine.
2. To acquire the skills of patient assessment necessary for the provision of optimal treatment plans.
3. To gain sufficient skill and judgment on the appropriate use and application of various spine management interventions considered standard-of-care.
4. To gain an understanding of the multidisciplinary nature of spine management, and to be able to coordinate and function in a collaborative fashion with other healthcare professionals.
5. To gain competency in the management of medications, modalities, therapies, and psychological support relating to spinal disorders.



PM&R SPINE MEDICINE FELLOWSHIP APPLICATION, The UCLA Spine Center

INSTRUCTIONS: PRINT OR TYPE ALL INFORMATION REQUESTED IN THE SPACE PROVIDED. IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET OF PAPER AND INDICATE THE SECTION/QUESTION TO WHICH YOUR CONTINUED RESPONSE RELATES.

1.	NAME (LAST)	(FIRST)	(MIDDLE)
2.	ADDRESS (STREET)	CITY	STATE ZIP CODE
3.	HOME PHONE	CELL PHONE	
4.	E-MAIL		

MEDICAL TRAINING & EDUCATION

RESIDENCY(S) – LIST MOST RECENT PROGRAM FIRST				NAME (LAST)
5.	NAME OF PROGRAM AND FACILITY	DATES FROM TO M/DD/YYYY M/DD/YYYY		
6.	ADDRESS (STREET)	CITY	STATE ZIP CODE	
7.	NAME OF PROGRAM DIRECTOR	PHONE NUMBER		(FIRST)
8.	NAME OF PROGRAM AND FACILITY <i>(if applicable)</i>	DATES FROM TO M/DD/YYYY M/DD/YYYY		
9.	ADDRESS (STREET)	CITY	STATE ZIP CODE	
10.	NAME OF PROGRAM DIRECTOR	PHONE NUMBER		(MIDDLE)
INTERNSHIP				
11.	NAME OF PROGRAM AND FACILITY	DATES FROM TO M/DD/YYYY M/DD/YYYY		
12.	ADDRESS (STREET)	CITY	STATE ZIP CODE	
13.	NAME OF PROGRAM DIRECTOR	PHONE NUMBER		

APPLICATION FOR PM&R SPINE FELLOWSHIP – PAGE TWO

MEDICAL TRAINING & EDUCATION (continued)

Jae Jung, MD: Program Director, The UCLA PM&R Spine Medicine Fellowship
 1250 16th Street Suite 3120, Santa Monica, CA 90404
 Tel: (424) 259-9871, FAX: (424) 259-6991

RESEARCH EXPERIENCE – LIST MOST RECENT EXPERIENCE.FIRST				
14. LOCATION (name of facility / business)		DATES FROM TO M/DD/YYYY M/DD/YYYY		
ADDRESS (STREET)	CITY	STATE	ZIP CODE	
15. DUTIES				
16. LOCATION (name of facility / business)		DATES FROM TO M/DD/YYYY M/DD/YYYY		
ADDRESS (STREET)	CITY	STATE	ZIP CODE	
17. DUTIES				
MEDICAL SCHOOL				
18. NAME		DATES FROM TO M/DD/YYYY M/DD/YYYY		DEGREE
19. ADDRESS (STREET)	CITY	STATE	ZIP CODE	
ADDITIONAL GRADUATE EDUCATION (if applicable)				
20. NAME		DATES FROM TO M/DD/YYYY M/DD/YYYY		DEGREE
21. ADDRESS (STREET)	CITY	STATE	ZIP CODE	

UNDERGRADUATE EDUCATION – LIST MOST RECENT EXPERIENCE FIRST				
22. NAME		DATES M/DD/YYYY M/DD/YYYY		DEGREE
23. ADDRESS (STREET)	CITY	STATE	ZIP CODE	
24. NAME		DATES M/DD/YYYY M/DD/YYYY		DEGREE
25. ADDRESS (STREET)	CITY	STATE	ZIP CODE	

APPLICATION FOR PM&R SPINE FELLOWSHIP – PAGE THREE
MEDICAL TRAINING & EDUCATION (continued)

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HONORS & AWARDS

Indicate any honors &/or awards you have received. (If additional space is required, please attach a separate sheet of paper. Be sure to include your name at the top.)

26. DATE RECEIVED	AWARD NAME / TYPE	REASON FOR RECEIPT
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27. DATE RECEIVED	AWARD NAME / TYPE	REASON FOR RECEIPT
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28. DATE RECEIVED	AWARD NAME / TYPE	REASON FOR RECEIPT
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EXAMINATION STATUS

I have already passed the examinations checked below on the dates indicated:

☐

USMLE, STEP 1 _____ (M/DD/YYYY)	<input type="checkbox"/> USMLE, STEP 2 _____ (M/DD/YYYY)	<input type="checkbox"/> USMLE, STEP 3 _____ (M/DD/YYYY)
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RESULTS	3-DIGIT / 2-DIGIT	3-DIGIT / 2-DIGIT	3-DIGIT / 2-DIGIT
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____ / ____

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<input type="checkbox"/> COMLEX 1 _____ (M/DD/YYYY)	<input type="checkbox"/> COMLEX 2 _____ (M/DD/YYYY)	<input type="checkbox"/> COMLEX 3 _____ (M/DD/YYYY)
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RESULTS	3-DIGIT / 2-DIGIT	3-DIGIT / 2-DIGIT	3-DIGIT / 2-DIGIT
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OTHER CERTIFICATIONS / LICENSES HELD

INDICATE OTHER CERTIFICATIONS / LICENSES, ETC. HELD. INCLUDE BOARD, YEAR CERTIFIED AND EXPIRATION DATE (if applicable)

BOARD	YEAR CERTIFIED _____	EXPIRATION DATE ____ / ____
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BOARD	YEAR CERTIFIED _____	EXPIRATION DATE ____ / ____
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APPLICATION FOR PM&R SPINE FELLOWSHIP – PAGE FOUR

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REVOCATIONS AND / OR DENIED PRIVILEGES

Have you ever been denied a medical license and / or hospital privileges?

(If **YES**, provide information concerning the incident(s). Use a separate piece of paper, if necessary.

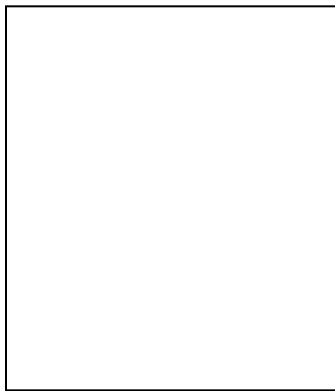
SERVICE OBLIGATION (National Health Service Corps, Armed Forces Scholarship, State Programs, Etc.)

☐ I AM NOT REQUIRED TO FULFILL ANY SERVICE OBLIGATION(S)

☐ I AM COMMITTED TO FULFILL A SERVICE OBLIGATION BEGINNING

M/DD/YYYY

NUMBER OF YEARS COMMITTED



PHOTOGRAPH: Including a recent photograph is optional at this time however, if you accept our Program's invitation to interview, you should be prepared to provide one.

I have read and understand the instructions for the completion of this application. Furthermore, I certify that the information submitted on this application is accurate and complete to the best of my knowledge. I understand that any false or omitted information may disqualify me for consideration of a Pain Medicine Fellowship position with your institution.

SIGNATURE OF APPLICANT:

(Signature must be original)

DATE:

APPLICATION FOR PM&R SPINE FELLOWSHIP – PAGE FIVE

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INSTRUCTIONS FOR SUBMITTING THE FELLOWSHIP APPLICATION
PLEASE READ CAREFULLY

All pages of the Application for PM&R Spine Medicine Fellowship form, with original signature, should be submitted along with the following supplementary documents to the address at the bottom of this page.

REQUIRED

- CURRENT CV
- PERSONAL STATEMENT (include information regarding your future medical goals, both short and long term)
- LETTERS OF RECOMMENDATION (3) – one must be from your Program Director
- MEDICAL SCHOOL DEAN'S LETTER (copy)
- MEDICAL SCHOOL TRANSCRIPTS (copy)
- MEDICAL SCHOOL DIPLOMA (copy)
- USMLE / NBOME SCORE REPORTS (Steps 1, 2, & 3)

OPTIONAL

- SAE-R SCORE REPORTS (copy)
- PHOTOGRAPH (passport size, head & shoulders only, recent)

COMPLETE applications will be forwarded to the Selection Committee for review and consideration of an interview.

DEADLINE

Application due by June 1st.

MAILING ADDRESS

The UCLA PM&R Spine Fellowship Program

ATTN: Monica Nget

1250 16th Street, Suite 3120

Santa Monica, CA 90404

QUESTIONS

PLEASE DIRECT ANY QUESTION VIA EMAIL.

pmrspinefellowship@mednet.ucla.edu