The Anesthesia Foundation
Helping Anesthesiologists Succeed

1061 American Lane
Schaumburg, IL 60173-4973

APPLICATION FOR LOAN

All fields required unless marked optional or if applicable

1. Name _____ Male ☐ Female ☐
   Last First Middle

2. Present address _____
   Street City State Zip Code

3. Permanent address (where mail will always reach you):

   _____

4. Social Security Number _____ Daytime phone number _____ Cell phone number _____

5. E-mail address _____

6. Birthplace _____ Age _____

7. I am a: ☐ U.S. Citizen ☐ Permanent Resident Alien ☐ Asylee

   ☐ Refugee Other _____

8. Medical schools

Name	Location	Degree	Date of Graduation

9. Internship(s)

Hospital	Location	Type	Dates

10. Residencies other than Anesthesia

Hospital	Location	Type	Dates

11. Other medical or scientific training or experience (if applicable)

Institution	Location	Type	Degree	Dates

12. Anesthesia training

a. Training to date

Institution	Location	Dates

Name of head of department _____

b. Plans for completing training _____

c. Expected Date of Completion _____

d. If institution in "b" differs from "a", explain why

_____

_____

13. Amount of Loan Requested ($7500 maximum)_____

14. Explain why a loan is necessary to complete your training in Anesthesiology

_____

_____

_____

_____

_____

_____

_____

_____

15. If you are receiving aid from any foundation or similar source, please provide the name and address and amount:

_____

16. What stipend do you now receive or expect to receive_____

17. References—persons from whom information can be obtained (Please include title and affiliation of each reference.) Reference letters must be from your Department Chair, Residency Program Director and Faculty Anesthesiology Staff Member. Additional references are optional.

Name Title Email

Department Chair: _____

Address City and State Zip Code

_____

Name Title Email

Program Director: _____

Address City and State Zip Code

_____

Name Title Email

Anesthesiology Staff: _____

Address City and State Zip Code

_____

Name Title Email

Additional Reference (Optional): _____

Address City and State Zip Code

_____

Name Title Email

Additional Reference (Optional): _____

Address City and State Zip Code

_____

The responses entered are complete and true, to the best of my knowledge. I understand that if approved, the funds will appropriately be used for financial assistance for my anesthesia training.

Date _____, 20____ _____

(Signature)

Printing your name constitutes your signature.

PLEASE RETURN THIS FORM BY EMAIL, FAX OR POST TO:

The Anesthesia Foundation
Attn: Diana Reznikov
1061 American Lane
Schaumburg, IL 60173
FAX (847) 825-1692
Email: d.reznikov@asahq.org
Telephone: (847) 825-5586