



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. Anesthesiology Residency
a. Training to date
Institution 1 Location Type Dates

Name of head of department _____

Institution 2

Location

Type

Dates

Name of head of department _____

b. Anesthesiology Fellowship

Institution

Location

Type

Dates

Name of Program Director _____

c. Plans for completing training _____

d. Expected Date of Completion _____

e. If institution 1 differs from institution 2 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

Address

City and State

Zip Code

Email

Department Chair: _____

Program Director: _____

Anesthesiology Staff: _____

Additional Reference (Optional): _____

Additional Reference (Optional): _____

I understand that if approved, the funds will appropriately be used for financial assistance for my anesthesia training.

Date _____, 20____

(Signature)

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

The Anesthesia Foundation

1061 American Lane

Schaumburg, IL 60173

FAX (847) 825-1692

Email: Cpguy.gulcHwpf cvkppB cucj sQti

Telephone: (847) 825-5586