**PARTNERS HEALTHCARE DEPARTMENT OF PSYCHIATRY**

**Geriatric Psychiatry Fellowship Application**

*Submission Instructions:* Please email or mail the completed application including a copy of your CV, a brief one-page personal statement discussing your background, experiences, and interests relevant to training in geriatric psychiatry, and a copy of your current professional licensure to Patricia Kneeland at [Pkneeland1@mgh.harvard.edu](mailto:Pkneeland1@mgh.harvard.edu) or via mail:

Patricia Kneeland

Geriatric Psychiatry Fellowship Coordinator

Massachusetts General Hospital

55 Fruit Street

Bulfinch Building, Suite 360

Boston, MA 02114

**Application Due Date**: May 1 of the year prior to entry.

*Interviews will be held in late spring/early summer of the year prior to entry. No formal binding response will be required until November 1.*

Recent Photograph

**Program Year to which you are applying: \_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- |
| Personal Information | | | | | |
| **Full Name:** |  | |  | |  |
| Last | | | First | | Middle name |
| **Current Address:** |  | | | |  |
| Street Address | | | | | Apartment |
|  |  | | |  |  |
| City | | | | State | ZIP Code |
| **Cell Phone:** |  | **Alternate Phone:** |  | | |
|  | | | | | |
| **Permanent**  **Address:** | Same as current | | | |  |
| Street Address | | | | | Apartment |
|  |  | | |  |  |
| City | | | | State | ZIP Code |
| **E-mail Address:** |  | | | | |
| **Social Security #:** |  | Citizenship: |  | | |
| **Date of Birth:** |  | **Place of Birth:** |  | | |
|  | | | | | |
| **Emergency Contact:** |  | | Relationship to you: | | |
| **Phone and email:** |  | | | | |

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| Education | | |
| **Undergraduate University/College** | **Dates of Attendance** | **Major/Degree (if any)** |
| **Name** |  |  |
| **City State** |  |  |
| **Name** |  |  |
| **City State** |  |  |
| **Graduate School** | **Dates of Attendance** |  |
| **Name** |  |  |
| **City State** |  |  |
| **Name** |  |  |
| **City State** |  |  |
| **Medical School** | **Dates of Attendance** |  |
| **Name** |  |  |
| **City State** |  |  |
| **Name** |  |  |
| **City State** |  |  |

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| --- | --- | --- | --- | --- |
| Internships/ Residencies/Fellowships and/or Clinical Experience | | | |  |
| **Position Title** | **Institution/Hospital** | **City, State, Country** | **Start/End Dates (mm/yy)** | **ACGME accredited?** |
|  |  |  |  | Yes  No  N/A |
|  |  |  |  | Yes  No  N/A |
|  |  |  |  | Yes  No  N/A |
|  |  |  |  | Yes  No  N/A |
|  |  |  |  | Yes  No  N/A |

Areas of Clinical Interest/Research Experience

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Honors/Awards

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| --- | --- |
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Professional Memberships

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Publications\*

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| --- | --- |
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***\* Please include a reprint of each publication if available and any other pertinent information***

EXAMINATION/CERTIFICATION/LICENSURE

**Have you taken and passed all 3 steps of the USMLE/COMLEX-USA?**  Yes  No

***If not, when do you intend to (re)take the exam?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes, please enter your scores: Step 1 \_\_\_\_ Step 2(CK) \_\_\_\_ Step 2(CS) \_\_\_\_ Step 3 \_\_\_**

**Do you have a license to practice medicine?**  Yes  No

**If yes, in which state?** \_\_\_\_\_\_ **License #:** \_\_\_\_\_\_\_\_\_\_

VISA STATUS

***If you are on a Visa, please complete the following:***  **N/A, I am not on a visa**

**Note:** only applicants with unrestricted licenses may participate in the non-ACGME programs.

**Type of Visa Do you intend to apply for U.S. citizenship?**  Yes  No

**J1** **H1** **Other \_\_\_ Have you completed all requirements necessary to apply for visa renewal?**

Yes  No ***If no, please explain on a separate sheet***

**If applicable, ECFGM Certificate Number \_**\_\_\_\_\_\_\_\_\_\_\_\_ ***(Please include a copy of your ECFMG certificate)***

Additional Information\*

**Have you ever been denied a medical license or had your license revoked, limited, restricted, or suspended?**

Yes  No

**Have you ever been placed on academic probation in medical school or residency training?**

Yes  No

**Have you ever been dismissed from an appointment to medical school, residency, fellowship or professional employment?**

Yes  No

**Do you have any pending or previous professional misconducts?**

Yes  No

**Is there a gap of six months or more on your CV since beginning medical school?**

Yes  No

***\* Please explain any affirmative answers on a separate sheet***

REFERENCES

***Below please list the names of 3 references. Note that all letters of reference must be submitted directly by the author (email is acceptable) One of these should be from the director of your psychiatry residency training program and the additional two should be from supervisors and attending staff with whom you have worked directly***

**Name Title Institution**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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*I certify that the information given in this application is true, complete, and accurate to the best of my knowledge and does not omit any material fact that would render the statement false, fictitious, or fraudulent as a result of the omission.*

**Applicant signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (Electronic signature is acceptable)

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Required Application Materials**

**Checklist**

\_\_\_\_\_\_Completed and signed application form

\_\_\_\_\_\_Curriculum Vitae

\_\_\_\_\_\_One-page personal statement including aspects of your background, experiences, and interests relevant to training in geriatric psychiatry

\_\_\_\_\_\_Copy of your current professional licensure

\_\_\_\_\_\_Written Statement if there are any interruptions in your medical education or training to date for academic disciplinary reasons please provide a separate written statement of explanation.

\_\_\_\_\_\_Three (3) letters of reference. One of these should be from the director of your psychiatry residency training program. The additional two should be from supervisors and attending staff with whom you have worked directly. \*\*Please have these sent directly to our program by the original author.