

Mass General Brigham Geriatric Psychiatry Fellowship Application

Submission Instructions: Please email or mail the completed application including a copy of your current 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:

Patricia Kneeland
MGB Geriatric Psychiatry Fellowship Coordinator
Massachusetts General Hospital
55 Fruit Street
Bulfinch Building, Suite 360
Boston, MA 02114

Application Acceptance to begin on: January 1st

Interviews will begin in February of the year prior to entry.

Program Year to which you are applying: _____

PERSONAL INFORMATION

Full Name:	_____	_____	_____
	<i>Last</i>	<i>First</i>	<i>Middle name</i>
Current Address:	_____	_____	_____
	<i>Street Address</i>		<i>Apartment</i>
	_____	_____	_____
	<i>City</i>	<i>State</i>	<i>ZIP Code</i>
Cell Phone:	_____	Alternate Phone:	_____
Permanent Address:	<input type="checkbox"/> Same as current		
	_____	_____	_____
	<i>Street Address</i>		<i>Apartment</i>
	_____	_____	_____
	<i>City</i>	<i>State</i>	<i>ZIP Code</i>
E-mail Address:	_____		

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		

INTERNSHIPS/ RESIDENCIES/FELLOWSHIPS AND/OR CLINICAL				
Position Title	Institution/Hospital	City, State, Country	Start/End Dates (mm/yy)	ACGME accredited?
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Areas of Clinical Interest/Research Experience

Honors/Awards

Publications*

* 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 H1 Other ____ Do you intend to apply for U.S. citizenship? Yes No J1
 Have you completed all requirements necessary to apply for visa renewal?
 Yes No *If no, please explain on a separate sheet*

If applicable, ECFMG 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 or No**

Have you ever been placed on academic probation in medical school or residency training? **Yes or No**

Have you ever been dismissed from an appointment to medical school, residency, fellowship or professional employment? **Yes or No**

Do you have any pending or previous professional misconducts? **Yes or No**

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

<u>Name</u>	<u>Title</u>	<u>Institution</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 – Most recent _____

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 coordinator by the original author

Pkneeland1@mgh.harvard.edu

1. _____

2. _____

3. _____