PARTNERS HEALTHCARE DEPARTMENT OF PSYCHIATRY
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 or via mail:

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 15th

Interviews will be held in spring of the year prior to entry.

Recent Photograph

Program Year to which you are applying: _____

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: _____

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?**
				☐ 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

Honors/Awards

Professional Memberships

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
◻ **J1** ◻**H1** ◻**Other** ___

Do you intend to apply for U.S. citizenship? ◻ Yes ◻ No
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**
_____	_____	_____
_____	_____	_____
_____	_____	_____

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. _____