EMORY UNIVERSITY SCHOOL OF MEDICINE

APPLICATION FOR GERIATRIC PSYCHIATRY FELLOWSHIP

POSITION BEGINNING IN _____

NAME	(Last)	(First)	(Middle)	
BIRTH DATE	**BIRTH PLACE**	**GENDER**	**EMAIL ADDRESS**	
		CITIZENSHIP	**VISA STATUS** (If Applicable)	
HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MIDEMEANOR? DO YOU HAVE LIMITATIONS?				
CURRENT ADDRESS	(Street)		(City, State, Zip)	(Country)
PHONE NUMBER	(Day)		(Evening)	
ARE YOU CERTIFIED BY THE ECFMG?		**ECFMG REGISTRATION NUMBER** (If Applicable)		
PERMANENT ADDRESS	(Street)		(City, State, Zip)	(Country)
ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES (BY US CITIZENSHIP OR BY IMMIGRATION VISA)? ☐ **YES** ☐ **NO**				

PRIOR TRAINING

SCHOOL NAME		(City)	(State)	(Country)
PGY YEAR(S)		**DATES/FROM-THROUGH**		
SCHOOL NAME		(City)	(State)	(Country)
PGYS YEAR(S)		**DATES/FROM-THROUGH**		

If additional space is needed, please attach a separate sheet

MEDICAL LICENSURE

TYPE	NUMBER	STATE	EXP. DATE

TYPE	NUMBER	STATE	EXP. DATE

MEDICAL EDUCATION

MEDICAL SCHOOL NAME	(City)	(State)	(Country)

MONTH/YEAR OF MATRICULATION	MONTH/YEAR OF GRADUATION

ELECTIVES COMPLETED

HONORS/AWARDS

GRADUATE EDUCATION

GRADUATE SCHOOL NAME	(City)	(State)	(Country)

MONTH/YEAR OF MATRICULATION	MONTH/YEAR OF GRADUATION

GRADUATE DEGREE	AREA OF STUDY

GRADUATE SCHOOL NAME	(City)	(State)	(Country)

MONTH/YEAR OF MATRICULATION	MONTH/YEAR OF GRADUATION

GRADUATE DEGREE	AREA OF STUDY

UNDERGRADUATE EDUCATION

UNDERGRADUATE SCHOOL NAME	(City)	(State)	(Country)
MONTH/YEAR OF MATRICULATION	**MONTH/YEAR OF GRADUATION**		
DEGREE	**AREA OF STUDY**		
UNDERGRADUATE SCHOOL NAME	(City)	(State)	(Country)
MONTH/YEAR OF MATRICULATION	**MONTH/YEAR OF GRADUATION**		
DEGREE	**AREA OF STUDY**		

EXAMINATIONS

USMLE STEP I	(Date Taken)	(Score)
USMLE STEP II	(Date Taken)	(Score)
USMLE STEP III	(Date Taken)	(Score)

SERVICE OBLIGATIONS

ARE YOU REQUIRED TO FULFILL ANY SERVICE OBLIGATIONS?

If Yes, please answer the following:

YOU ARE COMMITTED TO FULFILLING SERVICE OBLIGATIONS BEGINNING:

NUMBER OF YEARS COMMITTED:

PERSONAL STATEMENT

If additional space is needed, please attach a separate sheet

LETTERS OF REFERENCE

Photocopies of your completed file from your previous training program(s), including the Dean's letter and evaluation, should be sent as support for this application. Original letters of recommendation and evaluation from your previous Program Director(s) and hospital administrator(s), as listed below, are also required.

NAME AND TITLE

INSTITUTION

ADDRESS

NAME AND TITLE

INSTITUTION

ADDRESS

NAME AND TITLE

INSTITUTION

ADDRESS

NAME AND TITLE

INSTITUTION

ADDRESS

Check one:

☐ **I HEREBY WAIVE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS**

☐ **I DESIRE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHOURS**

I HAVE READ AND UNDERSTAND THE INSTRUCTIONS FOR THE COMPLETION OF THIS APPLICATION. I CERTIFY THAT THE INFORMATION SUBMITTED ON THESE APPLICATION MATERIALS IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THIS POSITION.

SIGNATURE: **DATE:**

NAME OF APPLICANT (PRINT OR TYPE)**:**