FELLOWSHIP APPLICATION FORM

University of Rochester and Highland Hospital

(Optional)

Attach
Your Photo

Eligibility Requirements*:*

- *Must obtain a NYS license before starting the Fellowship*
- *Have AAFP board certification (or eligible for certification)*
- *Intent to pursue a teaching and/or research career (not required for Maternal and Child Health program)*

PERSONAL DATA:

Name____

Address____
Street City State Zip

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ E-Mail Address: ____________________

Birth Date: ____________________ Citizenship: ____________________

If not a U.S. citizen, what type of visa do you have? ____________________

If not a U.S. citizen, give your ECFMG #: ____________________

Name of partner or closest relative: ____________________

Phone number of partner or closest relative: ____________________

EDUCATION:

Degree: (BS, BA, etc.)	University or College	Month	Year
Degree: (MD, DO, etc.)	University or College	Month	Year
Other Degree(s)	University or College	Month	Year

INTERNSHIP/RESIDENCY:

Name of U.S. Accredited Program	City/State	Specialty	Years

HOSPITAL/CLINICAL EXPERIENCE *(if any):*

Position	Hospital	City/State	Year

MEDICAL LICENSURE:

____
State(s) License #(s)

REFERENCES:
Please list three (3) individuals who will send us letters of recommendation, including one from the Program Director of your residency program or Department Chair. **Reference letters must be on their official letterhead, signed, sealed** and:

- Sent directly to the Fellowship Coordinator *(see address below)*
- Include reference to your clinical ability, professional qualification, and moral character.

1) ____
Name Title

____
Phone Number E-Mail Address

2) ____
Name Title

____
Phone Number E-Mail Address

3) ____
Name Title

____
Phone Number E-Mail Address

Have you ever been dismissed from, or disciplined by a previous residency or fellowship program? No ❑ Yes ❑
If Yes, explain: ____

Have you ever had a medical license suspended, revoked, denied or subject to disciplinary action? No ❑ Yes ❑
If Yes, explain: ____

Do you have any pending or previous professional misconduct, malpractice actions, judgments or settlements?
No ❑ Yes ❑ If Yes, explain: ____

Have you ever been convicted of a misdemeanor or felony? No ❑ Yes ❑
If Yes, explain: ____

FELLOWSHIP PROGRAM OF INTEREST:
(check all that apply)

❑ **Behavior Change**

❑ **Family Systems Medicine**

❑ **Health Care Disparities Research**

❑ **Idealized Medical & Micro-team Practice (IMMP)**

❑ **Maternal & Child Health**

❑ **Patient-Centered Care**

Please return this completed application, along with your current CV and a one-page personal statement outlining your professional goals to:

E-mail: Susan_Gardner@urmc.rochester.edu
Fax: (585) 473-2245

Susan Gardner, Fellowship Coordinator
Family Medicine Research Programs
1381 South Avenue
Rochester, NY 14620
Phone: (585) 506-9484 x128