

**UNIVERSITY OF ROCHESTER MCH
LEADERSHIP EDUCATION IN ADOLESCENT HEALTH
FELLOW APPLICATION FORM**

I. CONTACT INFORMATION

1. Name: _____ Date: _____
2. Social Security #: _____ Date of Birth: _____
3. Current Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: (w) _____ (h) _____
 E-Mail: _____
4. Permanent Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: (w) _____ (h) _____
5. Expected dates of Training: From ____/____/____ To ____/____/____
6. Training desired in what discipline: _____
7. How did you hear about our training program?
 Brochure _____
 Presentation _____ If checked, give date ____ mm ____ day ____ yr
 Letter _____ If checked, give date ____ mm ____ day ____ yr
 Professional Journal Advertisement _____ Name of Journal _____
 Other (please detail): _____

8. Citizenship: _____ U. S. _____ Permanent resident visa
(funding guidelines are limited to one of the above categories)

II. ACADEMIC INFORMATION

1. Highest degree achieved at this time _____ Discipline of this degree _____
 Other Degrees: Field of Study
 Bachelors _____ Medical/Doctorate _____
 Masters _____ Specialty Training (please specify) _____
2. During the training period, will you be pursuing an advanced academic degree/certification?
 _____ Yes _____ No
 If yes, please describe: _____
3. In the past, have you been a teacher or supervisor in higher education courses? _____ Yes _____ No
 If yes, please describe: _____

III. EMPLOYMENT

1. Are you currently employed? _____ Yes (Please continue with question #2)
 _____ No (Please skip to Section V)
2. Are you employed: _____ full or _____ part time?

3. Do you have supervisory responsibilities? Yes No
 If yes, please describe: _____

4. What percentage of time do you spend in each of the following areas?
 % Direct Services % Research
 % Training/teaching % Administrative/Supervisory
 % Private Practice % Other

5. Current Employment
 a. Name of organization _____
 b. City _____ State _____ Zip Code _____
 c. Date employment began _____
 d. Academic title (if applicable) _____
 e. Functional title _____

6. Primary type of Employment:
 Direct Service Governmental (Local, State, Federal)
 Private Practice Business/Consultative
 Teaching
 Other (Specify) _____

IV. PROFESSIONAL STATEMENT

Please attach a brief statement describing your career goals, with special attention to the contribution this training program will make toward your achieving your professional objectives, and include a copy of your curriculum vitae or resume.

V. LETTERS OF REFERENCE

Please indicate two individuals known to you professionally, who will provide letters of recommendation.

1. Name: _____
 Address: _____

2. Name: _____
 Address: _____

The letters of recommendation should be sent to:
 Richard E. Kreipe, MD
 Program Director
 Leadership Education in Adolescent Health
 601 Elmwood Avenue, Box 690
 Rochester, NY 14642