UNIVERSITY OF ROCHESTER
ADOLESCENT MEDICINE FELLOWSHIP
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
   _____ % Training/teaching
   _____ % Private Practice
   _____ % Research
   _____ % Administrative/Supervisory
   _____ % 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
   _____ Private Practice
   _____ Teaching
   _____ Other (Specify) ____
   _____ Governmental (Local, State, Federal)
   _____ Business/Consultative

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