

Date: _____

NAME (PRINT) _____
First Middle Last

SOCIAL SECURITY NO. _____

PRESENT ADDRESS _____ Phone _____
Street

_____ City State Zip Code

PERMANENT ADDRESS _____ Phone _____
Street

_____ City State Zip Code

E-MAIL ADDRESS _____

DATE OF BIRTH* _____ If not a US Citizen _____

PLACE OF BIRTH* _____ Type of Visa _____

CITIZENSHIP* _____ Immigration No. _____

Emergency Contact

SPOUSE/PARTNER* _____

OR NEAREST RELATIVE _____ Relation _____

ADDRESS OF RELATIVE _____ Phone _____

Do you have a commitment for military or National Health Corps Service? _____

APPLICATION FOR FELLOWSHIP TRACK (check appropriate track)

- Adult Ambulatory Track
- Primary Care Family Psychology
- Rochester PRIDE Track
- Child and Adolescent Track – specify focus _____

EDUCATION (Please include degrees to be granted and APA/CPA – accredited graduate program)

Degree (M.A., B.A., etc.)	University or College	Month	Year
Degree (Ph.D., Psy.D., etc.)	University or College	Month	Year
Other Degrees	University or College	Month	Year
Dissertation Title		Dissertation Defended?	Yes Date: _____ If No, Expected date: _____

HOSPITAL AND CLINICAL EXPERIENCE

(include APA accredited internship and other experience NOT listed on CV):

Position	Hospital	City	Dates
Position	Hospital	City	Dates

Ever resigned or withdrawn association from previous training program to avoid the imposition of disciplinary measures? Yes ___ No ___ Reason: _____

Ever disciplined by, or dismissed from, or not re-appointed to a previous training program? Yes ___ No ___ Reason: _____

Ever had professional licensure limited, restricted, suspended, revoked, denied or subject to probationary conditions? Yes ___ No ___ Reason: _____

Any pending or previous professional misconduct proceedings or pending or previous malpractice actions, judgments or settlements? Yes ___ No ___ Reason: _____

Ever been convicted of a misdemeanor or felony in any jurisdiction? Yes ___ No ___ Reason: _____

I certify that the information contained in this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a postdoctoral fellowship position. I further understand that upon appointment I will be required to document my citizenship and complete a health assessment that includes a physical examination and drug and alcohol testing.

Date Submitted _____ Usual Signature _____
(Written)

Send application materials to: Clinical Psychology Training Program, Department of Psychiatry, University of Rochester Medical Center, 300 Crittenden Boulevard, Rochester, NY 14642-8409

THIS APPLICATION BECOMES – FOR THOSE APPOINTED – A PERMANENT RECORD