



Geriatric Medicine Fellowship Application Form:

In addition to the completed application form, please submit each of the following items:

- 1) personal statement describing your interest in geriatrics and career goals
- 2) most recent copy of your curriculum vitae (CV)
- 3) Copy of USMLE Board Examination Score Summary
- 4) THREE letters of reference
(Please note: one of these letters must be from your current or most recent program director)

Please Note: for non-citizen applicants with training visas the geriatric Medicine Fellowship Program can only consider candidates with a current J-1 visa

Please send completed applications and supporting materials to:

Geriatric Medicine Fellowship Program Coordinator
University of Rochester
Division of Geriatrics & Aging
Monroe Community Hospital
435 East Henrietta Road
Rochester, NY 14620

or fax (585) 424-5725

For questions regarding the application:
Susan Darby (585) 760-6353
or email: Susan_Darby@urmc.rochester.edu



GRADUATE MEDICAL EDUCATION EMPLOYMENT APPLICATION FORM

Please Print/Type

Photo

Program Name Completing Application for:

Geriatric Medicine Fellowship Program

A recent photograph is not a requirement, but is very helpful

Anticipated Program Start Date: (please check one)

July 1, 2021 July 1, 2022 Other: _____

Last Name:

Middle Name:

First Name:

Contact Address:

Permanent Address:

Home Phone Number:	
Work Phone Number:	
Cell Phone Number:	
Fax Number:	
Email:	
National Provider Identifier Number:	
Gender:	

Birth Date: (mm/dd/yyyy)	
Birth Place:	
Citizenship Country:	
Visa Type (if applicable):	

Examinations

Examination	Status (Passed/Failed)	3- Digit Score	Date
USMLE Step 1			
USMLE Step 2 CK (clinical knowledge)			
USMLE Step 2 (clinical skills)			
USMLE Step 3			

Medical Licensure

Board Certification? (yes/no)	
If yes, which Board:	
Ever Named in a Malpractice Suit? (yes/no)	
State Medical License? (yes/no)	
If yes, which state, number, expiration date:	

Educational Commission for Foreign Medical Graduates Certification

Are you certified by the ECFMG? (yes/no)	
If yes, ECFMG Number:	

Medical Education

Institution & Location	Dates Attended	Degree	Date of Degree (mm/dd/yyyy)
Medical Education/Training Extended or Interrupted? (yes/no)			
If yes, the reason:			

Medical Education Honors/Awards

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Education (list all graduate and undergraduate schools)

Education (not medical)	Institution & Location	Dates Attended	Degree	Degree Date (mm/dd/yyyy)	Field of Study
Graduate					
Undergraduate					

Current/Prior Medical Training

Experience/Specialty	Institution & Location	Program Director	Dates Attended (mm/dd/yyyy)	Years of Training

Hospital and Clinical Work Experience

Position	Hospital/Practice Name	City/State/Zip	Dates From mm/dd/yyyy To mm/dd/yyyy

Publications

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Language Fluency (other than English)

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Hobbies & Interests

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Other Awards/Accomplishments

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If the answer to any of the questions below is “Yes,” provide a full explanation in the space provided at the end of this form.

1. Have you ever been reported to the National Practitioner Data Bank, Healthcare YES NO
Integrity and/or Protection Data Bank?
2. Has your employment, medical staff appointment, panel participation, affiliation YES NO
or clinical privileges ever been voluntarily or involuntarily suspended, diminished,
revoked, refused or limited in any hospital, health care facility or managed care
organization, IPA or PPO including to avoid disciplinary action for reasons related to
professional competence or conduct?
3. Has your license to practice your profession in any jurisdiction every been limited, YES NO
restricted, suspended, revoked, denied or subject to probationary conditions?
4. Have you ever voluntarily or involuntarily relinquished your license to practice YES NO
your profession in any state?
5. Have you ever been suspended, sanctioned or otherwise restricted from participating YES NO
in any private, federal or state health insurance program (including Medicare,
Medicaid or a managed care organization)?
6. Has your narcotics registration certificate ever been voluntarily or involuntarily YES NO
limited, restricted, denied renewal, suspended or revoked?
7. Have you ever been denied membership, membership renewal or been subject YES NO
to any professional review, censure or reprimand in any medical organization
or professional society – local, state or national?
8. Have you ever been subject to disciplinary action by a state agency or YES NO
professional body (i.e., Medical Society, IPRO, OPMC)?
9. Has your specialty board certification or qualification ever been voluntarily or YES NO
involuntarily denied, revoked, relinquished, not renewed, suspended or reduced?
10. Do you have any pending misconduct charges against you in this state or any other state? YES NO
11. Have you ever been convicted of a misdemeanor or felony in any jurisdiction? YES NO
12. Are you presently or have you ever been subject to any suspension, revocation, discontinuance, YES NO
limitation, restriction, monitoring or probationary proceedings?
13. Have you ever been cited for violation of patient rights as set forth by the YES NO
Federal Law and/or NYS Department of Health or any other state department of health?
14. Has your professional liability insurance coverage ever been surcharged, suspended YES NO
or terminated by action of any insurance company?
15. Has your professional liability insurance coverage ever been denied or not renewed YES NO
by action of any insurance company?
16. Has your present professional liability insurance carrier excluded any specific YES NO
procedures from your coverage? **If “Yes,” list the procedure(s), the date(s) the exclusion(s)
commenced in the space below.**

17. Have any professional liability suits been filed against you which are currently pending YES NO
in this or any other state?
18. Have any professional liability judgments and/or settlements ever been made against..... YES NO
you or on your behalf?

If “Yes” to any of the above questions, please explain:

If “Yes,” list the procedure(s) the date(s) the exclusion(s) commenced in the space below. (Question 16) #

Attestation: I hereby waive any confidentiality provision concerning the information provided in this application, pursuant to New York State Public Health Law section 2805-k.

1. I attest that the information provided is complete, true and accurate. TRUE FALSE
2. I agree to update this form while it is being processed, should there be any TRUE FALSE
change in the information provided.
3. I understand that any misrepresentation, misstatement or omission on this form TRUE FALSE
could result in revocation of any privileges/employment granted and subject to reporting
according to NYS regulations.
4. I am not currently using any illegal drug, nor have I during the past two years. TRUE FALSE
3. I authorize release of reference information by all past and present employers/ YES NO
educational institutions.

DATE: _____ APPLICANT SIGNATURE _____

APPLICANT PRINTED NAME _____