Application for Fellowship Training in Geriatrics

Division of Geriatric Medicine, Department of Internal Medicine
The University of Michigan Medical School, Ann Arbor, Michigan 48109-5797

Date________________________

I am applying for a Fellowship beginning: (Month)________________, (Year)______.

1. **Last Name:** _____________________ **First Name:** _____________________ **Middle Initial:** ___

Sex _______ U.S. Social Security No. _______________________

2. **Mailing Address:** ____
(Number & Street, Apt. #)
____
(City, State, Zip Code,Country)

3. **Telephone Numbers Where You May be Reached:** Home: _________________________
Work: _________________________
Cell (optional): _______________________

4. **E-mail Address:** ____________________________ **Fax Number:** _____________________

5. **Preferred Method of contact:** ____________________________

6. **Date and Place of Birth:** ________________________________

The following question is *optional*. This information will be used for statistical purposes only and will in no way affect your application.

7. Do you consider yourself to be a member of any of the following ethnic groups? If so, please check the box next to the group you most closely identify with.

☐ African American ☐ Asian American ☐ Hispanic ☐ Native American

8. **Citizenship:** Are you a U.S. citizen? Yes _____ No ______

To be completed by non U.S. citizen:

Country of citizenship: ___________________ Do you have U.S. entry visa? ______

If yes, Visa Type: J-1 ☐ H-1 ☐

Visa Number _______________ Permanent Resident ☐

If English is not your native language, **please present documentation** (in addition to the language examination of ECFMG) that your knowledge of the English language is sufficient to function as a Fellow in the United States. The most desirable documentation is a certificate by TOEFL (Test of English as a Foreign Language), Box 899, Princeton, New Jersey 08540, which can be taken around the world during the months of September, November, February, and May.

9. **Marital Status:** ___________________
If married, indicate name of spouse (including maiden name) _____________________________
Would your acceptance of a position be contingent upon your spouse/significant other finding a suitable position in Ann Arbor? Yes ☐ No ☐ If yes, please explain: ___________________
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List children's names and birthdates (optional) ______________________________________
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Education:

10. **Undergraduate College or University:**

Name & location of **Institution #1:** ____

Years (inclusive): ______________ Degree & Year: ________________________________

Field of Study: _______________________________________

Name & location of **Institution #2:** ____

Years (inclusive): ______________ Degree & Year: ________________________________

Field of Study: _______________________________________

11. **Graduate or Professional/Medical Schools:**

Name & location of **Institution #1:** ____

Years (inclusive): ______________ Degree: M.D. ☐ D.O. ☐ M.B.B.S. ☐ Year: ____

Field of Study: _______________________________________

Name & location of **Institution #2:** ____

Years (inclusive): ______________ Degree & Year: ________________________________

Field of Study: _______________________________________

Internship (Include name, location, years, specialty area): _______________________________
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Residency (Include name, location, years, specialty area): _______________________________
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12. **Other Fellowships, Scholarships, Traineeships/Internships:**

1 Awarding Agency: _____________________________ Place: _____________________________

Position: ___________________________ Inclusive Years: ____________________

2 Awarding Agency: _____________________________ Place: _____________________________

Position: ___________________________ Inclusive Years: ____________________

3 Awarding Agency: ____________________________ Place: ____________________________

Position: __________________________ Inclusive Years: ___________________

4 Awarding Agency: ____________________________ Place: ____________________________

Position: __________________________ Inclusive Years: ___________________

13. **Employment History since College and/or Medical School Graduation:**

List chronologically all positions held. Include each year since graduation from undergraduate college (if applicable) and Medical School:

Name & Address of Employer1: ____

Title of Position Held: _______________________ Dates from _____________ to ______________

Name & Address of Employer2: ____

Title of Position Held: _______________________ Dates from _____________ to ______________

Name & Address of Employer3: ____

Title of Position Held: _______________________ Dates from _____________ to ______________

Name & Address of Employer4: ____

Title of Position Held: _______________________ Dates from _____________ to ______________

Please list all *lapse of training* activities following graduation of medical school, including dates, location, and activities. ____

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14**. Military Service:** Branch __________________________ Rank ______________________

Position ___________________________ Inclusive Years ____________________

15. **Medical Practice Licensures:** ____

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USMLE (United States Medical Licensing Exam) Dates & 3-Digit Scores

Step I____________ Step II CK ___________ Step II CS ___________ Step III ____________

To be completed by foreign medical graduates:

ECFMG Certification is **mandatory** for those who intend to do clinical work.

ECFMG Number: __________________ Date: ____________ Clinical Assessment Score: ____

16. **Medical Specialty Board Certifications:**
Name of Board: ______________________ Year: _____ Country: ____________________
Name of Board: ______________________ Year: _____ Country: ____________________

17. **Extracurricular Activities:**
List Memberships in National, Professional, or Related Organizations:
Organization (Memberships) ____________________ Year ______
Organization (Memberships) ____________________ Year ______

Non-Professional: ____
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18. **Research Experience:** (Describe briefly any work you may have done in an area of biomedical research; indicate outcome of this research and your preceptor.) _____________________________
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List your Publications: ____
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19. **Academic Honors, Special Awards:** (Include Honor, “Awarded by” and Year)
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20. **Career Objective:**
(How would this Fellowship, if awarded, fit in with your career plans? Please answer in detail. Give any additional information to support your application.)
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Additional Information: ____

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21. **Documents in Support of Application**
Before your application can be considered:
Three letters of recommendation are required (one required from your Program Director) with a complete appraisal of your clinical and research abilities and originality (where applicable), professional qualifications, personality, and moral character. Applicant should arrange to have these submitted directly as confidential communications to address listed below. The individuals submitting letters of recommendation are:
Reference Number 1: (Name & address) ____

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Reference Number 2: (Name & address) ____

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Reference Number 3: (Name & address) ____

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22. **Personal Statement:** ____

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Please include a recent small **photograph of yourself (optional) and send to the mailing address below or as an attachment (jpg format) to GerMedFellowshipApps@umich.edu .

****Curriculum Vitae** can be sent as an additional attachment GerMedFellowshipApps@umich.edu .

All documents, information, letters of recommendation, and communications should be directed to Robert V. Hogikyan, M.D., M.P.H., Director, Geriatric Medicine Fellowship Program;
4260 Plymouth Rd. , Ann Arbor, Michigan 48109-5797. Please direct telephone inquiries to (734) 936-2519 or by email to GerMedFellowshipApps@umich.edu .