

Application for Fellowship Training in Hospice and Palliative Medicine

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

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: _____

List children's names and birthdates (not required) _____

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 & Year: _____

Field of Study: _____

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

Years (inclusive): _____ Degree & Year: _____

Field of Study: _____

Internship (Include name, location, years, specialty area): _____

Residency (Include name, location, years, specialty area): _____

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:

- 1. Name & Address of Employer: _____
Title of Position Held: _____ Dates from _____ to _____
- 2. Name & Address of Employer: _____
Title of Position Held: _____ Dates from _____ to _____
- 3. Name & Address of Employer: _____
Title of Position Held: _____ Dates from _____ to _____
- 4. Name & Address of Employer: _____
Title of Position Held: _____ Dates from _____ to _____

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

- 14. Military Service:** Branch _____ Rank _____
Position _____ Inclusive Years _____

15. Medical Practice Licensures (please list State, License #, Date issued and expiration date):

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

Step _____ 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 certified: _____

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: _____

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.) _____

List your Publications: _____

19. Academic Honors, Special Awards: (Include Honor, "Awarded by" and Year) _____

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.) _____

Additional Information: _____

21. Documents in Support of Application

Before your application can be considered:

Three letters of recommendation are required (one required from your Program Director or Department Chair) 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) _____

Reference Number 2: (Name & address) _____

Reference Number 3: (Name & address) _____

22. Personal Statement: _____

Please include a recent small **photograph** of yourself (optional) and send to the mailing address below.

****All documents, information, letters of recommendation, and communications should be directed to Marcos Montagnini, M.D., F.A.C.P.; Director, Palliative Medicine Fellowship Program; VA Ann Arbor Healthcare System, 2215 Fuller Road, (11G) GRECC F-224, Ann Arbor, Michigan 48105. Please direct telephone inquiries to (734) 845-3072 or by e-mail to mmontag@umich.edu**