**Application for Geriatric Psychiatry Fellowship Training**

**Name:**

*First Last Middle Initial*

**Applying for** (Specify Fellowship)*:* **Academic year:**

**Mailing address:**

**Email:**   **Date of birth:**

**Cell phone:**   **Alternate phone:**

**Social Security #:**   **ECFMG registration #** *(if applicable)***:**

**Citizenship:**   **Visa status:**  J-1  H-1  Other *specify:*

**If you require a visa, please provide your permanent address in your country of origin:**

**Have you participated in the NRMP?**  No  Yes **If "Yes," when?**

**If "Yes," what is your AAMC ID or other NRMP code?**

**Have you ever been convicted of a felony?**  Yes  No

**Are you required to fulfill any service obligations?**  Yes  No **If "Yes," beginning when?**

Undergraduate school(s) attended:

**Name:** **Years attended:**

**City, State and Country:** **Degree (if any):**

**Name:** **Years attended:**

**City, State and Country:** **Degree (if any):**

Medical and other graduate school(s) attended:

**Name:** **Years attended:**

**City, State and Country:** **Degree (if any):**

**Name:** **Years attended:**

**City, State and Country:** **Degree (if any):**

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Medical and other graduate school(s) attended (cont'd):

**Name:** **Years attended:**

**City, State and Country:** **Degree (if any):**

Residency and fellowship program(s) attended:

**Name:** **Years attended:**

**City, State and Country:** **Degree (if any):**

**Name:** **Years attended:**

**City, State and Country:** **Degree (if any):**

Please provide the following examination results:

|  |  |  |
| --- | --- | --- |
| **Exam** | **Status** *(indicate passed, failed, scheduled, or waiting to take)* | **Date(s) Taken or Scheduled** |
|  USMLE or  COMLEX Step 1 |  |  |
|  USMLE or  COMLEX Step 2 (Clinical Knowledge) |  |  |
|  USMLE or  COMLEX Step 2 (Clinical Skills) |  |  |
|  USMLE or  COMLEX Step 3 |  |  |

**Q1 Select the racial category or categories you most closely identify yourself with. (Check all that apply)**

* *-*Hispanic, Latino, or Spanish origin
* -American Indian or Alaska Native
* -Asian
* -Black or African American
* -Native Hawaiian or other Pacific Islanders
* -White
* ~~-~~Prefer to self-describe: (print)
* -Prefer not to answer

**Q2 What gender best represents how you think of yourself?(Check all that apply)**

Cis-gender:

* -Woman
* -Man

Transgender:

* -Woman
* -Man
* -Non-binary
* -Intersex
* -Prefer to self-describe: (print)
* -Prefer not to answer

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**Q3 *Which of the following best represents how you think of yourself? (Check all that apply)***

* -Heterosexual/straight
* -Gay
* -Lesbian
* -Bisexual
* -Pansexual
* -Asexual
* -Queer
* ~~-~~Prefer to self-describe: (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* -Prefer not to answer

**I certify that the information submitted on this application is complete and accurate. I understand that any false, missing or misleading information may disqualify me for this position.**

**Signature of Applicant:**   **Date:**

Additional Documents to be Submitted:

1. **CV**
2. **Personal Statement**
3. **Two Letters of Recommendation**\*
4. **Letter from Current or Most Recent Program Director outlining completed rotations and Clinical Exams**
5. **USMLE or COMLEX scores**\*
6. **Medical School Dean’s Letter**\*
7. **Medical School Transcript**\*
8. **Medical School Diploma**
9. **ECFMG Certificate (if applicable)**

*\*Please have these documents sent directly from the person or institution to the address below.*

Submit this application and the additional documents noted above to:

|  |  |  |
| --- | --- | --- |
| **Geriatric Psychiatry** | Attn: Carol Gunnoud  Yale University  Alzheimer's Disease Research Unit  1 Church Street, Suite 600  New Haven, CT 06510 | [carol.gunnoud@yale.edu](mailto:carol.gunnoud@yale.edu) |

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