



Dear Fellowship Applicant:

Thank you for inquiring about the University of Alabama at Birmingham (UAB) Geriatric Medicine Fellowship Program. Attached you will find an application for fellowship training available through the Southeast Center of Excellence in Geriatric Medicine (SCEGM), a Hartford Foundation-funded initiative. Because the SCEGM is a joint program of Emory University and UAB, you may use this application to apply to either or both programs.

Items required as part of your application include:

- Application
- Personal Statement
- Curriculum Vita
- Professional References
- 3 Letters of recommendation sent directly from the persons making the recommendation
 - one must be from your Program Director
- Copy of USMLE Step 1 exam result
- Copy of USMLE Step 2 exam result
- Copy of USMLE Step 3 exam result
- Copy of ECFMG certificate
- Copy of Medical degree

Please send your completed application to:

Dr. Angela Curtis
UAB Geriatric Education Manager
1530 3rd Avenue South, CH-19, 218S
Birmingham, Alabama 35294-2041
Phone 205-975-6649; FAX 205-975-5870;
E-Mail: acurtis@aging.uab.edu

Sincerely,

Richard V. Sims, MD
Geriatric Fellowship Program Director
UAB Division of Gerontology & Geriatric Medicine



Fellowship Application

Southeast Center of Excellence in Geriatric Medicine

Richard M. Allman, M.D., Co-Director
Division of Gerontology and Geriatric Medicine
201 CH19-933 South 19th Street
The University of Alabama at Birmingham
1530 3rd Avenue South
Birmingham, Alabama 35294-2041
Ph. 205-934-9261; FAX 205-934-7354

Theodore Johnson, M.D., Co-Director
Emory University
Division of Geriatric Medicine and Gerontology
1841 Clifton Road, N.E.
Atlanta, Georgia 30329
Ph. 404-728-6317; FAX 404-728-6425

This application can be used for either or both Fellowship Programs. Please indicate preference:

UAB Only

Emory Only

Consider for both programs

Name _____ Social Sec. No. _____/_____/_____
(Last) (First) (Middle)

Date of Application ____/____/____ Requested start date (month/year) _____
(Mo) (Day) (Yr)

I am most interested in the following training opportunity (check one):

Clinical Training (PGY 4 - one year)

Academic Track (clinical PGY 4 + research training PGY 5-6)

Research Track (PGY 5-6)

Other, _____

This application is for a PGY position of: Fourth Year – PGY 4 Fifth Year – PGY 5 Sixth Year – PGY 6

Part I Demographic Data

Present Address _____
(Street) (City) (State) (Zip)

Permanent Address _____
(Street) (City) (State) (Zip)

Present Telephone (_____) _____ Permanent Telephone (_____) _____

E-mail _____ Beeper No. (_____) _____

Citizen of _____ (If not a citizen of the United States, Page 4 Section V, must be completed)
(Country)

Name of Spouse (if applicable) or nearest relative _____
(Last) (First) (Middle)

Address of spouse / nearest relative _____
(Street) (City) (State) (Zip) (Phone #)

Military Service:

Dates, rank, and location _____

List any relevant skills acquired during military service: _____

Emory University and The University of Alabama at Birmingham are equal opportunity employers and educators that do not discriminate on the basis of race, color, national origin, sex, religion, disability, age, veteran status, or any grounds prohibited by state or local laws.

Part II Education

UNDERGRADUATE EDUCATION (List in chronological order)

Name of School	City / State	Dates: From - To	Degree / Date

GRADUATE OR PROFESSIONAL EDUCATION (Including Medical School)
(If Medical School is not LCME accredited, Page 4 Section V must be completed)

Name of School	City / State	Dates: From - To	Degree / Date

National Boards Part I _____ / _____ Part II _____ / _____ Flex Examination _____ / _____
 (Date taken) (Score) (Date taken) (Score) (Date taken) (Score)

USMLE Step 1 _____ / _____ / _____ Step II _____ / _____ / _____ Step III _____ / _____ / _____
 (Date taken) Score Percentile (Date taken) Score Percentile (Date taken) Score Percentile

POST-GRADUATE MEDICAL TRAINING:

Residency (PGY 1)	Specialty	Name of Institution, City, State	Dates: From - To
Residency (PGY 2)			
Residency (PGY 3)			

OTHER POST-GRADUATE TRAINING:

Dates	Name of Institution, City, State	Type of Training	Chief of Service

POST-GRADUATE RESEARCH TRAINING:

Dates	Name of Institution, City, State	Type of Training	Chief of Service

Previous Educational or Research Experience:

Licensure (full license, permit, certificate of registration, etc., where applicable):

Description	State	Number	Date of Issue	Expires
Medical License				

DEA Number: _____ Expiration Date: _____

Part III Professional data:

Organization Memberships _____

Honors _____

Extracurricular Activities _____

Bibliography (List all authors in proper sequence, name of article, journal, inclusive pages, dates; use additional page if necessary. Enclose one reprint of each article)

Part IV Background data: Please answer the following standard, required questions below.

Health Status: Number of days lost due to illness in past year _____ Nature of illness: _____

Do you now abuse chemical substances as defined below? Yes No
(Substance abuse is defined as using drugs for nonmedical reasons in an attempt to influence the mind and body, to alter emotions and senses, and to escape reality. A drug can be considered as any substance, other than food and including alcohol, that has an effect on the central nervous system or other systems of the body.)

Are you currently engaged in the illegal use of drugs? Yes No

*Have you ever been convicted of any charge(s) related to or pertaining to chemical substance abuse, or to the possession, sale or other distribution of illegal or legally controlled substances? Yes No

Other Charges and Violations: Are you now under charges for any violation of law or have you ever been convicted of or forfeited collateral for any violation of the law punishable by imprisonment of longer than one year, except for: traffic fines of \$100 or less; any offense committed before your 18th birthday adjudicated in a juvenile court or under a youth offender law; or any conviction for which the record has been expunged under federal or state law?

Yes No

To your knowledge, are you now under investigation or charges for any crime? Yes No

Is there any medical malpractice action or claim pending against you? Yes No

Is there currently or has there ever been a medical malpractice action or claim against any former employer which involved you? Yes No

Has there ever been a medical malpractice judgment against or involving you or a monetary settlement of a malpractice claim involving you? Yes No

Have you ever been refused medical licensure? Yes No

Has your medical license ever been suspended or revoked? Yes No

Have you ever been denied medical staff privileges, or had your medical staff privileges suspended or revoked? Yes No

If you answered "Yes" to any of the above, give details. For each, give date, charge, place, court, and action taken. (Use additional sheets if needed.)

*Please note that criminal conviction(s) will not automatically disqualify qualified applicants from the fellowship program(s).

Part V Information Required of Non-US Citizens and Graduates of Non-LCME Schools:

Visa Type and Status Type _____ Expiration Date _____
(Attach copy of VISA)

ECFMG Certificate No. _____ Date of Issue _____ Valid Through _____
(Attach copy of valid certificate)

FMGEMS _____ Part I _____ Part II _____
(Date taken) (Score) (Score)

Flex Examination _____
(Date taken) (Score)

ECFMG _____
(Date taken) (Score)

Part VI Personal Statement:

Please write a statement of your interest in Geriatric Medicine and your long-term career objectives (using complete sentences and additional sheets of paper if necessary).

Letters of recommendation: (Applicant should request they be sent directly to either or both of the Center's Co-Directors at the address(es) shown on the front of this application).

1. Department Chairman or Residency Program Director
2. Two other physicians who are qualified to evaluate the applicant's ability and qualifications for the specific fellowship.

I certify that the answers to the foregoing questions are true and complete to the best of my knowledge and belief, and are made in good faith. I give SCEGM, the University of Alabama at Birmingham, and Emory University the right to contact all persons (organizations) named to gain information relevant to this application. I understand and specifically authorize that information bearing on my professional qualifications, credentials, clinical competence, knowledge, abilities, character, ethics, conduct and any other matter having a bearing on my application for this fellowship and prior training may be furnished to SCEGM, the University of Alabama at Birmingham, and Emory University. With regard to the release of information authorized herein, I hereby waive any privilege or confidentiality concerning this information. I hereby release the provider organization, SCEGM, the University of Alabama at Birmingham, the University of Alabama Health Services Foundation, and Emory Healthcare, Inc., Emory University, and Emory University doing business as Emory University School of Medicine, and each of their respective officers, trustees, agents and employees, from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized above. I understand that my provision of any false information or willful or negligent misrepresentation, or my failure to disclose any requested information will constitute sufficient grounds for disqualifying my application or my discharge from the fellowship program without notice. I acknowledge by my signature that I have read and understand these statements.

Signature of Applicant (sign in ink)

Date