**UWHC Graduate Medical Education Application**

**(for non-ERAS applicants)**

All required fields are marked with an asterisk (\*). Please note, however, that some of these fields are required only in certain circumstances. For example, if you state that you did earn or expect to receive a degree from an institution, you will be required to enter what that degree is.

**Program Applying For:** **Geriatric Psychiatry Fellowship**

**Training Year Applying For:**

**Anticipated Post Graduate Level:**

**Profile:**

First Name:       Middle Name:       Last Name:       Suffix:

Previous Last Name:

**Degree:**

[ ]  MD [ ]  MD, PhD [ ]  DO [ ]  MBBS [ ]  MBchS [ ]  MBChB

**Current Address:**

Street Address:

City:       State/Province:       Post Code:       Country:

Preferred Phone:       Alternate Phone:       Mobile:

Pager:       Fax:       Contact Email:

**Permanent Mailing Address:**

Street Address:

City:       State/Province:       Post Code:

Country:       Phone:

**NPI Number:**

**Military:**

Are you committed to fulfill U.S. Military active duty service obligations/deferments? \*

[ ]  Yes [ ]  No

If Yes: Years:       Branch:

Do you have any other service obligations? (i.e., Military Reserves or Public Health/State programs) \*

[ ]  Yes [ ]  No

Description (up to 255 characters)

**Citizenship:**

[ ]  U.S. Citizen

[ ]  Permanent legal residency status in the US (green card)

[ ]  EAD (Employee Authorization Document)

[ ]  Eligible to hold a J-1 Clinical Visa sponsored by ECFMG

* 1. Canadian Citizen

[ ]  Visa Change of Status – **J-1 “research scholar” to J-1 “alien physician”**

***Note: H-IB visa (temporary professional worker)***

***As an employer, UWHCA does not sponsor an H-1B visa for graduate medical education training.***

**International Medical Graduates:**

Are you certified by the Educational Commission for Foreign Medical Graduates?

(Attach a copy of the ECFMG certificate).

[ ]  No [ ]  Yes Month:       Year:

USMLE/ECFMG ID:

[ ]  ECFMG certificate is attached with the application. \*

**Non-Medical Education:**

For each non-medical educational institution you have attended, please provide the requested information. You may create as many entries as needed on an additional page.

[ ]  **None**

**#1**

Institution:       Location:

Education Type: \* Major:       Degree expected or earned: \* [ ]  Yes [ ]  No

Degree:       Degree Month:       Degree Year:

Dates of Attendance: From:       To:

 Month/Year Month/Year

**#2**

Institution:       Location:

Education Type: \* Major:       Degree expected or earned: \* [ ]  Yes [ ]  No

Degree:       Degree Month:       Degree Year:

Dates of Attendance: From:       To:

 Month/Year Month/Year

**[ ]** Refer to attachment for additional information. (Reference as 2-a, 2-b)

**Medical Education:**

For each medical school you have attended, please provide the requested information. You may create as many entries as needed on an additional page.

Please note: All time after medical school must be accounted for.

**#1**

Country:       Institution:

Clinical Campus:       \* only available for select US Medical Schools

Degree expected or earned: \* [ ]  Yes [ ]  No

Degree:       Degree Month:       Degree Year:

Dates of Attendance: From:       To:

 Month/Year Month/Year

**#2**

Country:       Institution:

Clinical Campus:       \* only available for select US Medical Schools

Degree expected or earned: \* [ ]  Yes [ ]  No

Degree:       Degree Month:       Degree Year:

Dates of Attendance: From:       To:

 Month/Year Month/Year

[ ]  Refer to attachment for additional information. (Reference as 3-a)

**Previous Training:**

For each internship, residency, or fellowship position you have held or currently are in, regardless of the amount of time spent there, please provide the requested information. You may create as many entries as needed on an additional page.

[ ]  None

**#1**

Specialty:

Type of Training: [ ]  Internship [ ]  Residency [ ]  Fellowship [ ]  Chief Resident

Dates of Residency/Fellowship: From:       To:

 Month/Year Month/Year

Institution/Program:

City:       State/Province:       Country:       Years:

Program Director:       Supervisor:

**#2**

Specialty:

Type of Training: [ ]  Internship [ ]  Residency [ ]  Fellowship [ ]  Chief Resident

Dates of Residency/Fellowship: From:       To:

 Month/Year Month/Year

Institution/Program:

City:       State/Province:       Country:       Years:

Program Director:       Supervisor:

**#3**

Specialty:

Type of Training: [ ]  Internship [ ]  Residency [ ]  Fellowship [ ]  Chief Resident

Dates of Residency/Fellowship: From:       To:

 Month/Year Month/Year

Institution/Program:

City:       State/Province:       Country:       Years:

Program Director:       Supervisor:

**Was your medical education/training extended or interrupted?**

Please explain any gaps of three or more months during your medical education and / or residency training? \*

[ ]  No

[ ]  Yes - Reason (up to 510 characters)

[ ]  Refer to attachment for additional information. (Reference as 3-b)

**Boards:**

Are you Board Certified?

[ ]  No

[ ]  Yes Board Name Expiration

**Examinations:**

For each examination you have taken, please provide the requested information. This worksheet has space for you to make 4 entries. (Osteopathic applicants: include the exams (COMLEX or USMLE) that lead to the medical licensure route you intend to pursue.)

[ ]  None

**Exam #1:** [ ]  1st attempt [ ]  2nd attempt

Title: Status:

 Month/Year

**Exam #2:** [ ]  1st attempt [ ]  2nd attempt

Title: Status:

 Month/Year

**Exam #3:** [ ]  1st attempt [ ]  2nd attempt

Title: Status:

 Month/Year

**Exam #4:** [ ]  1st attempt [ ]  2nd attempt

Title: Status:

 Month/Year

**Experience(s):**

For each non-residency relevant work, research, and volunteer experience/position you have had, please provide the requested information. Include non-residency clinical and teaching experience as work experiences, and include all unpaid extra-curricular activities and committees you have served on as volunteer experiences. This application has space for you to make two entries. You may create as many entries as needed on an additional page.

[ ]  None

**#1**

Type: [ ]  Work [ ]  Research [ ]  Volunteer

Organization:       Position:       Supervisor:

Average Hours Per Week:       Dates of Experience: From:       To:

 Month/Year Month/Year

Description (up to 1020 characters)

Reason for leaving (up to 510 characters)

**#2**

Type: [ ]  Work [ ]  Research [ ]  Volunteer

Organization:       Position:       Supervisor:

Average Hours Per Week:       Dates of Experience: From:       To:

 Month/Year Month/Year

Description (up to 1020 characters)

Reason for leaving (up to 510 characters)

[ ]  Refer to attachment for additional information. (Reference as 4-a)

Appendix A: **Personal / Demographic Information**

**This information will not be available to decision-makers prior to a position being offered through a match or non-match process.**

Applicant Name:

Program Name: Geriatric Psychiatry Fellowship

**Social Security Number:**

**Marital Status:** **[ ]** Married **[ ]** Single

**Gender:** [ ]  Female [ ]  Male

**Birth:** Birth Date:       Birth City:

Birth State:       Birth Country:

**Racial and Ethnic Group:**

This section allows entries for race self-identification. You may select one or more races. You are not required to identify your race. If you choose not to, please select "No Answer." Specify "other" if your race is not listed. You may create as many entries as needed.

[ ]  **Black (not of Hispanic Origin):** All persons having origins from any of the black racial groups.

[ ]  **Asian or Pacific Islanders:** All persons having origins from any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, Samoa, and India.

[ ]  **American Indian or Alaskan Native:** All persons having origins of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

[ ]  **Hispanic:** All persons from Mexican, Puerto Rican, Cuban, Central or South American, Iberian Peninsula, or other Spanish culture or Origin, regardless of race.

[ ]  **White (not of Hispanic Origin):** All persons having origins from any of the original peoples of Europe, North Africa, and the Middle East.

**[ ]  Unknown**

[ ]  **Other** \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix B: **Conviction and Accommodations**

**This sheet will be removed before decision makers decide who to interview. Information below may be discussed during the interview. Information on this page is necessary only after the applicant has been offered an interview.**

Applicant Name:

Program Name: Geriatric Psychiatry Fellowship

**Felony Question:**

Have you ever been convicted of a felony? [ ]  Yes [ ]  No

Have you ever been convicted of a misdemeanor? [ ]  Yes [ ]  No

\*\* *Section 111.321, Wis. Stats., generally prohibits employment discrimination on the basis of arrest or conviction record. An employer may only refuse to hire a qualified applicant because of a conviction record for an offense that is substantially related to the circumstances of a particular job. The legislature has determined that certain convictions are substantially related to employment in child and adult care giving programs regulated by the Department of Health and Family Services.*

**Work Eligibility:**

Are you able to carry out the responsibilities of a resident in the specialties and at the specific training programs to which you are applying including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations? \*

[ ]  Yes

[ ]  No – Pleased describe limiting aspects: