HONORHEALTH®

GERIATRIC MEDICINE FELLOWSHIP

APPLICATION FORM*****

Demographic Information:

Name (last, first, middle): _____

Address (present): _____

Telephone (xxx-xxx-xxxx): _____

E-mail: _____

Please select the eligible ACGME-accredited residency program that you graduated from:

☐ Family medicine ☐ Internal medicine

PLEASE NOTE: We do NOT sponsor visas. Please do not proceed with completing this application if you did not graduate from an ACGME – accredited Internal Medicine or Family Medicine Program or require a visa sponsor.

Have you ever been convicted of a criminal offense, either misdemeanor or felony other than minor traffic violations? ☐ Yes ☐ No

If yes, please explain here

_____

_____

_____

Has your medical license ever been revoked or put on probation status? ☐ Yes ☐ No

If yes, please explain here

_____

_____

_____

HONORHEALTH®

GME Education and Training: *Please provide a photocopy of each certificate.*

Residency: _____

Institution City and State Years at Institution

Residency: _____

Institution City and State Years at Institution

Fellowship: _____

Institution City and State Years at Institution

Fellowship: _____

Institution City and State Years at Institution

USMLE/COMLEX Step III Date Passed: _____

Medical School(s): *Please provide a photocopy of each medical school diploma.*

Institution	Inclusive Dates	Degree(s)	Major	Minor
Institution	Inclusive Dates	Degree(s)	Major	Minor

Graduate Program(s):

Institution	Inclusive Dates	Degree(s)	Major	Minor
Institution	Inclusive Dates	Degree(s)	Major	Minor

Undergraduate Program(s):

Institution	Inclusive Dates	Degree(s)	Major	Minor
Institution	Inclusive Dates	Degree(s)	Major	Minor

Medical Licensure(s):

1. State: _____ License: _____ Status: _____
2. State: _____ License: _____ Status: _____
3. State: _____ License: _____ Status: _____

Board Certification: *If yes, list each specialty.*

Board certified: ☐ Yes ☐ No

Specialty: _____ Date: _____

Specialty: _____ Date: _____

Specialty: _____ Date: _____

Board Eligibility: *If yes, list each specialty.*

Board certified: ☐ Yes ☐ No ☐ N/A

Specialty: _____ Date Planned: _____

Specialty: _____ Date Planned: _____

Specialty: _____ Date Planned: _____

References:
Please provide the names of three current professional references.

1. _____
   Name | Title & institution | Telephone | E-mail

2. _____
   Name | Title & institution | Telephone | E-mail

3. _____
   Name | Title & institution | Telephone | E-mail

Other Supporting Materials: *Please provide/attach the following documents to this application.*

- ☐ Curriculum vitae
- ☐ Personal statement describing your interest in and commitment to a career in geriatric medicine as well as your career goals upon fellowship completion
- ☐ Three letters of recommendation, one of which should be from your department head, program director or division chief
- ☐ Official medical school transcripts
- ☐ Official test transcripts for all applicable examinations (USMLE or COMPLEX)
- ☐ A valid ECFMG certificate (if you graduated from medical school outside of the United States)

Digital Signature: _____ Date: _____

Submitting Application and Supporting Documents:
Please e-mail this document with all requested information to GeriatricsFellowship@honorhealth.com

***Applications for future recruiting cycles will need to be submitted through ERAS**