

Application Form
Geriatrics Fellowship Training



Reply to: Traci Child
Geriatrics Fellowship Coordinator
Department of Internal Medicine
5323 Harry Hines Blvd.
Dallas, TX 75390-8889
214-648-9012

APPLICATION FOR FELLOWSHIP TRAINING

Complete all sections. Print or type all entries. If space provided is insufficient, please provide full details on separate sheet of paper. Please include your curriculum vitae and **please do not staple documents.**

Name: _____

Address: _____

Telephone: _____ Email: _____

Social Security #: _____

Birthdate: _____ Sex: _____ Marital Status: _____

Ethnicity: American Indian Asian African-American Hispanic
 Caucasian Other _____

Are you a citizen of the United States? Yes _____ No _____

If not, do you have a visa that allows employment? Yes _____ No _____

Please indicate what type of visa _____

EDUCATION

College/University _____

Dates _____ Major _____ Degree Granted _____

College/University _____

Dates _____ Major _____ Degree Granted _____

MEDICAL EDUCATION

Medical School _____

Dates _____

Please request that each of your graduate education schools send an official copy of your transcript directly to this office.

RESIDENCY

Hospital _____

Dates _____ Type _____

Name of Program Director _____

PERSONAL STATEMENT – Please complete the personal statement form (see next page).

In your personal statement please indicate your expectations for this fellowship program and your professional goals upon completion of this fellowship.

PROFESSIONAL REFERENCES

Please provide the names, addresses, and telephone numbers of three referees. Please ask them to mail the references directly to this office.

Indicate preferred starting date: _____

Please be certain to send us your medical school transcripts and ECFMG documentation.

PERSONAL STATEMENT

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that any false statements made herein will void this application and will be cause for discharge. I understand that any offer of employment tendered me is contingent upon my agreement to abide by the rules and regulations of The University of Texas Southwestern Medical Center. I authorize you to contact referees and former employers.

Signed: _____ Date: _____

Official Use Only

Application Received _____	File Completed _____
Committee Route _____	Recommendation _____
Notification to Applicant _____	

Please attach
photo here