

THE DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE

Thomas Jefferson University

GERIATRIC MEDICINE FELLOWSHIP

APPLICATION FORM

To Begin July: 2010 2011 2012

PERSONAL DATA:

NAME: _____

PRESENT STREET ADDRESS: _____

HOME TELEPHONE: () _____ WORK TELEPHONE: () _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____

CITIZENSHIP: _____ If not U.S., VISA TYPE: _____

COLLEGE EDUCATION

School(s): _____

Major/Degree: _____ Date: _____

MEDICAL EDUCATION

School(s): _____

Major/Degree: _____ Date: _____

POSTGRADUATE EDUCATION

	Program	Location	Dates
--	---------	----------	-------

Internship: _____

Residency: _____

Please indicate the exams you have taken:

- | | | |
|--|---|--|
| <input type="checkbox"/> NBME, Part 1 | <input type="checkbox"/> NBME, Part II | <input type="checkbox"/> NBME, Part III |
| <input type="checkbox"/> USMLE, Step 1 | <input type="checkbox"/> USMLE, Step II | <input type="checkbox"/> USMLE, Step III |
| <input type="checkbox"/> Flex I | <input type="checkbox"/> Flex II | |

ADDITIONAL MATERIAL: The following material should be sent along with your completed application:

Curriculum Vitae. Enclose a curriculum vitae (or resume) with this application.

Statement of Goals. Attach a statement (no more than one page) describing:

- a) the type of career you intend to pursue and your teaching and research interests
- b) how the fellowship will contribute to your career goals.

Copies of Examination Scores.

RECOMMENDATION FORMS: This application packet includes three recommendation forms, one being sent by your residency program director and two others for additional references. You should complete the top half of all three forms before forwarding them to references. Recommendations are confidential and should be sent directly to the address below no later than **November 1st**.

Send all application materials to the address below. Applications received by **November 1st** will be given first priority.

**Cynthia L. Branch
Fellowship Coordinator
Department of Family and Community Medicine
Thomas Jefferson University
1015 Walnut Street, 401 Curtis
Philadelphia, PA 19107-5099
(215) 955-0638**

Thomas Jefferson University is an
Equal Opportunity/Affirmative Action Employer

THE DEPARTMENT OF FAMILY MEDICINE

THOMAS JEFFERSON UNIVERSITY

CONFIDENTIAL RESIDENCY PROGRAM DIRECTOR'S RECOMMENDATION

TO THE APPLICANT: Complete and sign the top section of this form, then forward it to your residency program director.

APPLICANT'S NAME: _____

MAILING ADDRESS: _____

OFFICE TELEPHONE: () _____

REFERENCE'S NAME: _____

In signing this request, I signify my consent to have the requested letter of recommendation sent to the Fellowship Director in the Department of Family and Community Medicine.

Signature

Date

TO THE RESIDENCY PROGRAM DIRECTOR: The above named applicant has expressed interest in our Fellowship in Family Medicine. We would appreciate your candid assessment of the applicant's qualification for the Fellowship. In addition to your own observations, please provide specific comments about the following:

1. Length of time and capacity in which you have known the applicant.
2. Your knowledge of the candidate's career plans, his/her ability to carry them out, and the extent to which they reflect potential interest in academic family medicine.
3. Strengths the candidate has that will make him/her a productive participant in the fellowship program.

Your prompt response will be greatly appreciated. All replies will remain confidential. Please do not send your recommendation to the applicant; send it to the address below no later than November 1st.

**Cynthia L. Branch
Fellowship Coordinator
Department of Family Medicine
Thomas Jefferson University
1015 Walnut Street, 401 Curtis
Philadelphia, PA 19107-5099
(215) 955-0638**

THE DEPARTMENT OF FAMILY MEDICINE

THOMAS JEFFERSON UNIVERSITY

CONFIDENTIAL RECOMMENDATION

TO THE APPLICANT: Complete and sign the top section of this form, then forward it to the reference.

APPLICANT'S NAME: _____

MAILING ADDRESS: _____

OFFICE TELEPHONE: () _____

REFERENCE'S NAME: _____

In signing this request, I signify my consent to have the requested letter of recommendation sent to the Fellowship Director in the Department of Family and Community Medicine.

Signature

Date

TO THE REFERENCE: The above named applicant for our fellowship in family medicine has named you as one of three references. We would appreciate your candid assessment of the applicant's qualification for the fellowship. In addition to your own observations, please provide specific comments about the following:

1. Length of time and capacity in which you have known the applicant.
2. Your knowledge of the candidate's career plans, his/her ability to carry them out, and the extent to which they reflect potential interest in Academic Family Medicine.
3. Strengths the candidate has that will make him/her a productive participant in the fellowship program.

Your prompt response will be greatly appreciated. All replies will remain confidential. Please do not send your recommendation to the applicant; send it to the address below no later than November 1st.

**Cynthia L Branch
Fellowship Coordinator
Department of Family Medicine
Thomas Jefferson University
1015 Walnut Street, 401 Curtis
Philadelphia, PA 19107-5099
(215) 955-0638**

THE DEPARTMENT OF FAMILY MEDICINE

THOMAS JEFFERSON UNIVERSITY

CONFIDENTIAL RECOMMENDATION

TO THE APPLICANT: Complete and sign the top section of this form, then forward it to the reference.

APPLICANT'S NAME: _____

MAILING ADDRESS: _____

OFFICE TELEPHONE: () _____

REFERENCE'S NAME: _____

In signing this request, I signify my consent to have the requested letter of recommendation sent to the Fellowship Director in the Department of Family and Community Medicine.

Signature

Date

TO THE REFERENCE: The above named applicant for our fellowship in family medicine has named you as one of three references. We would appreciate your candid assessment of the applicant's qualification for the fellowship. In addition to your own observations, please provide specific comments about the following:

1. Length of time and capacity in which you have known the applicant.
2. Your knowledge of the candidate's career plans, his/her ability to carry them out, and the extent to which they reflect potential interest in Academic Family Medicine.
3. Strengths the candidate has that will make him/her a productive participant in the fellowship program.

Your prompt response will be greatly appreciated. All replies will remain confidential. Please do not send your recommendation to the applicant; send it to the address below no later than November 1st.

**Cynthia L. Branch
Fellowship Coordinator
Department of Family Medicine
Thomas Jefferson University
1015 Walnut Street, 401 Curtis
Philadelphia, PA 19107-5099
(215) 955-0638**