



# FELLOWSHIP PROGRAM APPLICATION

Specify Program: Geriatric Medicine Circle year PGY 4 5 6 7 Date Program to Begin: \_\_\_\_\_

Name in Full: \_\_\_\_\_  
Last                      First                      Middle                      (Maiden name, if applicable)

Present Address: \_\_\_\_\_  
(Number & Street)                      (City)                      (Zip Code)                      (Phone Number)

Permanent Address: \_\_\_\_\_  
(Number & Street)                      (City)                      (Zip Code)                      (Phone Number)

U.S. Citizenship: \_\_\_\_\_ Yes                      \_\_\_\_\_ No                      Social Security Number: \_\_\_\_\_  
If no, Visa Type: \_\_\_\_\_                      Visa Number: \_\_\_\_\_                      Expiration Date: \_\_\_\_\_

Licensing Examinations:  
 National Boards: Part 1 Passed (Date): \_\_\_\_\_ Part II Passed (Date) \_\_\_\_\_ Part III Passed (Date) \_\_\_\_\_  
 USMLE: Step 1 Passed (Date): \_\_\_\_\_ Step 2 Passed (Date) \_\_\_\_\_ Step 3 Passed (Date) \_\_\_\_\_  
 Flex: Passed (Date): \_\_\_\_\_

State(s) in which licensed (attach copies of license and current registration certificate): \_\_\_\_\_

**Education and Professional Experience: Provide a continuous history for all years from high school graduation to present. Attach CV or list on separate page if additional space is needed. If a foreign graduate, attach a copy of your ECFMG certificate and scores on the FMGEMS or other exams.**

Name & Location	Attendance	Major or Training Program	Degree or Certificate	Date Awarded
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**References: List name, position and address of three persons who are acquainted with your academic and professional experience, and from whom you will request confidential statements in support of your application. Direct letters of recommendation and verification from ALL POSTGRADUATE TRAINING are required. These letters must include beginning and ending dates for each period of training or employment.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**My letter of application, which outlines my academic objectives, is attached. My official transcript will be sent directly from each medical school attended. A list of publications and/or academic awards (if any) is attached.**

Signature of Applicant: \_\_\_\_\_

**PLEASE SEND YOUR COMPLETED APPLICATION TO:**

Winthrop University Hospital  
 Division of Geriatric Medicine  
 Fellowship Coordinator  
 222 Station Plaza North, Suite 518  
 Mineola, NY 11501  
 Fax: 516-663-4644