

**Forensic Psychiatry Fellowship Program**

Please submit the following documents to the fellowship program:

Common Application Form

Photo

Curriculum Vitae

Personal statement of one single-spaced page or less that explains your interest and/or experience in forensic psychiatry

At least one additional writing sample (e.g., de-identified forensic report or psychiatric evaluation, published manuscript of which you are the first author)

Copy of medical school diploma

Copy of ECFMG certificate (if applicable)

Copy of current medical license(s)

Copy of USMLE/COMLEX scores

Please request that the following documents are sent directly to the fellowship program from the source:

3 letters of reference, one of which must be from your current program director or, if you have completed training within the past five years, the director of the program from which you graduated most recently

Official copy of medical school transcript and dean’s letter

*Please note that some programs may require a secondary or university-specific application. You should contact the programs directly to inquire about additional application requirements.*

**Forensic Psychiatry Fellowship**

**Common Application Form**

**GENERAL INFORMATION**

Full Name *(first, middle, last):*

Preferred Name:

Date of Birth:

Current Address *(street, city, state, zip code, country)*:

Cell Phone:       Alternate Phone:

Email Address:

Languages Spoken *(indicating level of fluency)*:

**EDUCATION** (Undergraduate, Medical School, Other)

|  |  |  |
| --- | --- | --- |
| **University/College** | **Degree Obtained** | **Month & Year of Graduation** |
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# RESIDENCY & FELLOWSHIP TRAINING

|  |  |  |  |
| --- | --- | --- | --- |
| **Institution/Hospital** | **City, State, Country** | **Start Date (mm/yy)** | **End Date (mm/yy)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**REFERENCES**

*Please list the names of three individuals from whom you have solicited letters of reference. If you are currently a trainee or have completed training within the last five years, at least one of the letters must be from your most recent Residency or Fellowship Program Director.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Title** | **Institution** | **Email address** | **Phone number** |
|  |  |  |  |  |
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|  |  |  |  |  |

**CERTIFICATION & LICENSURE**

Have you passed all three steps of the USMLE/COMLEX-USA? Yes No

ECFMG Number (if applicable):

Do you have a license to practice medicine? Yes No

If yes, in which state(s)?       License Number(s):       Expiration date(s):

Are you Board Certified in psychiatry or any other specialty? Yes No

If yes, which other specialty or specialties?

**CITIZENSHIP & VISA INFORMATION**

Citizenship:

Visa Status: N/A J-1 H-1 Other (please specify):

Have you completed all necessary requirements for visa renewal to cover the period of your fellowship training?

Yes No

*If no, please attach a written explanation.*

# ADDITIONAL INFORMATION

# *If you answer “yes” to any of the questions below, please attach a written explanation.*

# Have you ever been denied a medical license or had your license revoked, limited, restricted, or suspended?

Yes No

Have you ever been placed on academic probation while in medical school or residency/fellowship training?

Yes No

Have you ever been dismissed from an appointment to medical school, residency, fellowship, or professional employment? Yes No

Have you ever resigned from any employment position, including a residency or fellowship program?

Yes No

Do you have any pending or previous professional misconduct allegations? Yes No

Have you ever been convicted of a felony, and/or do you currently have any pending criminal charges?

Yes No

Is there a gap of six months or more (without education, training, or professional employment) on your CV since beginning medical school? Yes No

# ATTESTATION

*I certify that the information provided in this application is complete and accurate. I understand that any false, missing, or misleading information may disqualify me from a fellowship position.*

Printed Name:       Date:

Signature:

**RELEASE FROM LIABILITY**

*I concur that immunity be extended to all persons and institutions furnishing information of my qualifications to the fellowship programs and to their affiliated hospitals. Such immunity shall cover all acts and statements made in good faith and without malice.*

Printed Name:       Date:

Signature: