

**THE DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE**

**Thomas Jefferson University**

**GERIATRIC MEDICINE FELLOWSHIP**

**APPLICATION FORM**

To Begin July:  2012  2013  2014  2015

**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
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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 MATERIALS:** The following material should be sent along with your completed application:

- **Curriculum Vitae.** Enclose a curriculum vitae (or resume) with this application.
- **Personal Statement.** 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 USMLE Examination Scores (Steps 1, 2 and 3)**
  - **MT/MD License**
  - **Three Letters of Recommendation (one being addressed by your Residency Program Director)**

**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.

Send all application materials to the address below:

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

**NOTE: Applications will be received on a continuous basis year-round. Interview season begins in early fall (September).**

Thomas Jefferson University is an  
Equal Opportunity/Affirmative Action Employer

**THE DEPARTMENT OF FAMILY AND COMMUNITY 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:

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

**THE DEPARTMENT OF FAMILY AND COMMUNITY 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:

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