

**ADDICTION MEDICINE FELLOWSHIP APPLICATION**

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| **Date:** | **Start Date: July 1, 2020** |
| **Last Name:** | **First Name: Middle Initial:** |
| **Home Address:** | **Telephone:** |
| **City:** | **State: Zip:**  |
| **Email Address:** | **Birth Date: Birth Place:** |
| **Citizenship:** | **ECFMG Status & Number (Enclose Copy with Application).** |
| **Visa Status & Number (if applicable):** | **USMLE Score (Enclose Copy with Application).** |
| **PREMEDICAL EDUCATION** |
| **Institution:** | **Address:** | **From:** | **To:** | **Degree:** |
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| **MEDICAL EDUCATION** |
| **Institution:** | **Address:** | **From:** | **To:** | **Degree:** |
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| **PROFESSIONAL TRAINING** |
| **Position:** | **City:** | **Institution:** | **Type of Service:** | **From:** | **To:** |
| **Internship:** |  |  |  |  |  |
| **Residency:** |  |  |  |  |  |
| **Fellowship:** |  |  |  |  |  |
| **Other Post Graduate Work Experience -** **Including current hospital staff membership.** |  |  |  |  |  |
| **REFERENCES** |
| **Please list three reference and include letters of recommendation with your application. Please do not have letters of recommendation sent separately to program coordinator – LETTERS OF RECOMMENDATION MUST BE INCLUDED WITH APPLICATION.** |
| **Name:** | **Title:** | **Address & Phone Number:** |
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| **Are you Board Certified? 󠇯** □ **No** □ **Yes If Yes, state Board name (Enclose Copy with Application).** |
| **Are you DEA registered? 󠇯** □ **󠇯No**  □ **󠇯Yes If yes, provide registration number and expiration month/year (Enclose Copy with Application).** |
| **Are you currently licensed to practice medicine in the United States? 󠇯** □ **󠇯No** □ **Yes** |
| **Military service obligation/deferment?** □ **No** □ **Yes** |
| **List honors, scholarships, grants, etc.** |
| **Has your Medical License ever been suspended/revoked/voluntarily terminated? 󠇯 󠇯** □ **No** □ **Yes** **If Yes, please give a complete explanation on a separate piece of paper.** |
| **Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges? 󠇯 󠇯****If Yes, please give a complete explanation on a separate piece of paper.** |
| **Have you ever been convicted of a felony?** □ **No** □ **Yes****If Yes, please give a complete explanation on a separate piece of paper.** |
| **Are you able to carry out the responsibilities of a fellow in this program including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?** □ **No** □ **Yes****If No, please describe limiting aspects on a separate piece of paper.** |
| **Personal statement describing your personal interest and objectives in pursuing a career in palliative medicine.** **(Enclose on a separate sheet of paper with application).** |
| **Email (paper application will not be accepted) completed application with requested documents to Laurie Lemmel @** **Laurie.Lemmel@ucdenver.edu****.** 1. □ **Fellowship Application**2. □ **Curriculum Vitae (CV)**3. □  **Personal Statement** 4. □ **3 Letters of Recommendation** 5. □ **State Medical License**6. □ **DEA License – if applicable**7. □ **Medical School Diploma**8. □ **USMLE/COMLE Scores**9. □ **ECFMG Status & Number – if applicable** |

**APPLICANTS AFFIDAVIT:**

**I certify that the information contained in this application is complete and accurate to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment. I hereby authorize my present and past employers to furnish the University of Colorado with records of service if requested.**

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**Signature Date**