

All applicants for the fellowship program must be physicians who:

- A. Have successfully completed an ACGME accredited residency program per the Executive Director of the RRC for Palliative Medicine.
- B. Be board-certified or board-eligible in another medical specialty
- C. Currently have or are able to obtain a license to practice medicine in Alabama *prior to* the date the fellowship is scheduled to begin
- D. Verify that visa status is current if a foreign graduate. Candidate will also be required to meet with a representative of the UAB International Scholar and Student Services office to assure full compliance with all federal and state policies.

The following documentation is required of all applicants in order for their file to be considered complete. Please be sure to include each of these documents when submitting your package in order to assure our prompt consideration of your application.

- Completed **application** form with a recent photograph attached
- Curriculum Vitae** (*must be month/year specific*)
- One page **Personal Statement** that outlines your purpose in pursuing a career in Palliative Medicine, including a statement of career goals)
- Copy of current **state medical license**
- Copy of current **DEA certificate**
- Copy of **all USMLE or FLEX board certificates**
- Notarized** copy of your **medical school diploma**
- Certified** medical school **transcript**
- Copy of Medical Student Performance Evaluation (**MSPE**, or “Dean’s letter”)
- Copy of **residency certificate** when available
- Copy of all **board certification certificates, if applicable**
- Three letters of reference.** One should be from director of your residency program. These letters should be solicited by you, not by our office, should be current, and should not be solicited from a member of the UAB Palliative Medicine Fellowship Committee. Letters should be sent directly to the program office by referees. (CH19 Suite 219, 1720 2nd Ave. So., Birmingham, AL 35294-2041)
- For foreign graduates only:** Copy of your Green Card or proof of U.S. citizenship or visa status.
- For foreign graduates only:** Notarized copy of your ECFMG Certificate



Center for Palliative and Supportive Care Palliative Medicine Program

Attach recent
photograph

APPLICATION FOR FELLOWSHIP TRAINING

(Type or Print)

Date of Application ____ / ____ / ____
(Mo) (Da) (Yr)

Social Sec. No. ____ / ____ / ____

Name _____
(Last) (First) (Middle)

Present Address _____
(Street) (City) (State) (Zip)

Permanent Address _____
c/o (Name) (Street) (City) (State) (Zip)

Present Telephone (_____) _____ Permanent Telephone (_____) _____

Citizen of _____ (If not U.S. citizen, must fill out page 3)
(Country)

The following sociodemographic data are requested (optional):

Birthdate ____ / ____ / ____ Birth Place _____ Sex _____
(Mo) (Da) (Yr) (City/State)

Race _____ Marital Status _____ No. Dependents _____

Name of Spouse _____
(If Applicable) (Last) (First) (Middle)

Nearest Relative _____ Phone # _____

and Address _____

UNDERGRADUATE EDUCATION (List in chronological order)

Name of School	City / State	From	Date	To	Degree / Date

GRADUATE OR MEDICAL EDUCATION (Including Medical School) (If Medical School is not LCME accredited, page 3, bottom, must be completed)

Name of School	City / State	From	Date	To	Degree / Date

MAILING ADDRESS: CH19 219, 1720 2ND Ave. So., Birmingham, AL 35294-2041
DELIVERY ADDRESS: 933 19th Street So., Birmingham, AL 35205

An Affirmative Action/Equal Opportunity Employer

National Boards Part I _____ / _____ (Date taken) (Score) Part II _____ / _____ (Date taken) (Score) Flex Examination _____ / _____ (Date taken) (Score)

USMLE Step I _____ / _____ / _____ (Date taken) Score Percentile Step II _____ / _____ / _____ (Date taken) Score Percentile Step III _____ / _____ / _____ (Date taken) Score Percentile

PREVIOUS POSTGRADUATE TRAINING (Residency or Fellowship)

Specialty	(Mo/Yr)	to	(Mo/Yr)	Certificate Earned?
Institution Name			City/State	
Specialty	(Mo/Yr)	to	(Mo/Yr)	Certificate Earned?
Institution Name			City/State	
Specialty	(Mo/Yr)	to	(Mo/Yr)	Certificate Earned?
Institution Name			City/State	

Recommendations: List those asked to write letters of recommendation (Indicate name, address, and position):

(1) _____

(2) _____

(3) _____

(4) _____

LICENSURE (full license, permit, certificate of registration, etc., where applicable; See #5 under Application Procedures):

Description	State	Number	Date of Issue	Expires
Medical/Dental License	_____	_____	_____	_____
DEA Number:	_____	_____	_____	_____
State Controlled Substances Certificate:	_____	_____	_____	_____
Other (Specify)	_____	_____	_____	_____

PREVIOUS EDUCATIONAL OR RESEARCH EXPERIENCE, INCLUDING PUBLICATIONS:

Honors: _____

Extracurricular Activities _____

Military Status: _____
nature of your discharge?

Were you ever convicted
by a court-martial? _____

Health Status: Number days lost last year due to illness _____ Nature of illness _____

*Do you now abuse chemical substances, as defined herein? Yes _____ No _____

Have you ever been convicted of any charge(s) related to or pertaining to chemical substance abuse, or to the possession, sale or other distribution of illegal or legally controlled substances? Yes _____ No _____

*(Substance abuse is defined as using drugs for nonmedical reasons in an attempt to influence the mind and body, to alter emotions and senses, and to escape reality. A drug can be considered as any substance, other than food and including alcohol, that has an effect on the central nervous system or other systems of the body.)

Other Charges and Violations:

Are you now under charges for any violation of law or have you ever been convicted of or forfeited collateral for any violation of law punishable by imprisonment of longer than one year, except for: traffic fines of \$100 or less; any offense committed before your 18th birthday adjudicated in a juvenile court or under a youth offender law; any conviction for which the record has been expunged under federal or state? Yes _____ No _____

Is there any malpractice action or claim pending against you? Yes _____ No _____

Has there ever been a malpractice judgment against you or a monetary settlement of a claim against you? Yes _____ No _____

Have you ever been refused medical licensure? Yes _____ No _____

Has your medical license ever been suspended or revoked? Yes _____ No _____

Have you ever been denied medical staff privileges, or had your medical staff privileges suspended or revoked? Yes _____ No _____

If you answered "Yes" to any of the above, give details. For each, give (1) date, (2) charge, (3) place, (4) court, (5) action taken, use additional sheets if necessary. _____

INFORMATION REQUIRED OF NON-U.S. CITIZENS AND GRADUATES FROM NON-LCME SCHOOLS

Visa Type and Status (Attach copy of VISA) Type _____ Exp. date _____

ECFMG Certificate No. _____ Date Issued _____ Valid Through _____
(Attach copy of certificate)

FMGEMS: _____ Part I _____ Part II _____
(Date taken) (Score) (Score)

Flex Examination _____ / _____
(Date taken) (Score)

ECFMG: _____ / _____
(Date taken) (Score)

I CERTIFY that the answer to the foregoing questions are true and complete to the best of my knowledge and belief, and are made in good faith. I give UAB the right to contact all persons (organizations) named to gain information relevant to this application. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute sufficient grounds for UAB to terminate my fellowship without notice. I acknowledge by my signature that I have read and understand these statements.

Signature of Applicant (sign in ink)

Date

MAILING ADDRESS: CH19 219, 1720 2ND Ave. So., Birmingham, AL 35294-2041
DELIVERY ADDRESS: 933 19th Street So., Birmingham, AL 35205