UAB CENTER FOR PALLIATIVE AND SUPPORTIVE CARE
Palliative Medicine Fellowship

## APPLICATION

We begin accepting applications, either directly through our application form or through the Electronic Residency Application Service (ERAS) at http://bit.ly/1bsCMrJ on December 1st on an 18-month cycle (e.g. applications submitted on December 1, 2013 will be for the incoming class of July 1, 2015). ERAS closes on May 31st of the following year, but we continue to accept applications on a rolling basis and will interview until we have filled all of our positions for the academic year. **Currently we are interviewing and filling one year in advance**.

**Please contact us to see if we are still accepting applications for any given academic year or if you have any questions about the application process.**

The following documentation is required of all applicants in order for their file to be considered complete. Interviews will not be offered until files are complete. Please be sure to include each of these documents in order to assure prompt consideration of your application.

- Completed application form with a recent photograph
- Curriculum vitae (must be month/year specific)
- Personal statement (1-page 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 medical school diploma
- Certified medical school transcript
- Copy of Medical Student Performance Evaluation (MSPE, or "dean's letter")
- Copy of residency certificate when available
- Three (3) Letters of reference (one should be from director of residency program; must be solicited by applicant and sent directly to the program office)

  1720 2nd Avenue South
  CH19, Suite 219
  Birmingham, AL 35294-2041

- *For foreign medical graduates*: Copy of Green Card, proof of US citizenship, or current visa status.
- *For foreign medical graduates*: Notarized copy of ECFMG Certificate

### Terms, Conditions, & Benefits

Detailed terms and conditions of appointment may be found in the UAB Graduate Medicine Education (GME) Policies and Procedures Manual at http://bit.ly/1cwHIgt.

Only applicants who meet all of the following criteria may be accepted into our accredited training program sponsored by UAB University Hospital:

- Are graduates *or* will graduate from an ACGME- or AOA-accredited residency program in Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Obstetrics & Gynecology, Pediatrics, Physical Medicine & Rehabilitation, Psychiatry, Radiation Oncology, or Surgery, as determined by the Residency Review Committee (RRC) of Hospice & Palliative Medicine.
- Are board-certified *or* board-eligible in one of the above medical specialties.
- Are licensed *or* will be licensed to practice medicine the State of Alabama prior to the start date of fellowship training.

- Are US citizens *or* hold a valid visa for graduate medical education in the US. Candidates must meet with the UAB International Scholar & Student Services to ensure that the applicant holds an appropriate visa or to assist in the processing of the paperwork required for full compliance with states and federal policies.

An explanation of fellow salary and benefits can be found in the UAB Resident Benefits Summary at http://www.uab.edu/medicine/home/residents-fellows/current/resident-physician-salary-benefits.

# 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

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

USMLE Step I _____ / _____ / _____ Step II _____ / _____ / _____ Step III _____ / _____ / _____
(Date taken) Score Percentile (Date taken) Score Percentile (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: _____ Were you ever convicted by a court-martial? _____
nature of your discharge?

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

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