Addiction Medicine Fellowship
Application Instructions

1. Complete the application form.

2. Send the following documentation with the application: Updated Curriculum Vitae. Describe any gaps of more than one month in education or training, if applicable.

3. Personal Statement describing your interest in Addiction Medicine and plans for future professional work.

4. Attestations page with your signature.

5. Request a minimum of three letters of reference from faculty members. Letters must be sent directly to the Program Coordinator or Program Director.

6. A copy of your Medical School Transcript and Dean’s Letter must be sent directly to Program Coordinator.

7. Mail (or send electronically, if appropriate) the completed application package to include the Application, Personal Statement, and your CV.

8. Contact information:
   Haley Weber, Fellowship Coordinator
   352-294-4904
   hweber@ufl.edu
   UF Health Florida Recovery Center / Admin Building
   3939 SW 13th Street
   Gainesville, FL 32608

   William Greene, MD, Program Director
   352-265-5549
Addiction Medicine
Fellowship Application Form

Date of Application: ____________ Anticipated Start Date for Addiction Medicine training: ____________

Full Name: __________________________________________________________________________________

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Current PG Yr: ___________________________ PG- level on start date: _____________________________

Present Mailing Address: __________________________________________

Permanent Mailing Address: ________________________________________

Telephone: Home: ____________________ Office: ____________________ Cell: ____________________

Email Address: ____________________________________________________

Place of Birth: ______________________________________ DOB: _______________________

Legally eligible to work in USA? _________________ Visa Status _______________________

MDs: List USMLE dates and scores below:

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<th>USMLE Step I</th>
<th>USMLE Step II</th>
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<th>USMLE Step III</th>
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DOs: List COMLEX Dates and Scores below:

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<th>Level 2</th>
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ECFMG Number and Date ________________________________________________

Board Certification: If Board Certified, list name of Board and Year of Certification below:

_________________________________________________________________________
LICENSURE:
State ________ Number ______________ Date ______________ Type________ Date ______________

Educational Data

Undergraduate Education: Please provide full name and mailing address for all schools listed.

Start and End Dates: ____________ to _____________ List Degree awarded: ______________________

________________________ Protect ______________ Street Address

City and State

Start and End Dates: ____________ to _____________ List Degree awarded: ______________________

________________________ Protect ______________ Street Address

City and State

Graduate Education - (Medical and Masters or Doctoral Program)

Start and End Dates: ____________ to _____________ List Degree awarded: ______________________

________________________ Protect ______________ Street Address

City and State

Start and End Dates: ____________ to _____________ List Degree awarded: ______________________

________________________ Protect ______________ Street Address

City and State
Postgraduate Medical Education:

**INTERNSHIP:** (if more than one, please provide additional information on a separate sheet)

Start_________________ to _______________                               ACGME Accredited: ______________________
(Month/Day/Year)            (Month/Day/Year)      Yes ☐ or ☐ No

____________________________________________    __________________________________________
Institution Name                                                           Street Address
___________________________________________  _________________________________________

LIST SPECIALTY

City and State

**RESIDENCY:** (if more than one, please provide additional information on a separate sheet)

Start_________________ to _______________                               ACGME Accredited: ______________________
(Month/Day/Year)            (Month/Day/Year)      Yes ☐ or ☐ No

____________________________________________    __________________________________________
Institution Name                                                           Street Address
___________________________________________  _________________________________________

LIST SPECIALTY

City and State

**FELLOWSHIP:** (if more than one, please provide additional information on a separate sheet)

Start_________________ to _______________                               ACGME Accredited: ______________________
(Month/Day/Year)            (Month/Day/Year)      Yes ☐ or ☐ No

____________________________________________    __________________________________________
Institution Name                                                           Street Address
___________________________________________  _________________________________________

LIST SPECIALTY

City and State
OTHER Professional training:

________________________________________________________________________________________

Start ___________________ to ___________________
(Month/Day/Year) (Month/Day/Year)

ACGME Accredited: ______________________

Yes □ or □ No

________________________________________________________________________________________

Institution Name

Street Address

________________________________________________________________________________________

LIST SPECIALTY

City and State

☐ Please check this box if you are attaching additional pages
**Personal Statement**
Describe your interest in Addiction Medicine and explain your plans for future professional work.

Name: ________________________________________
Attestations

Circle Yes or No in response to each question below. If you answer “Yes” to any of the questions, please attach a written explanation on a separate page for each question.

Malpractice

Have you received any settlements, malpractice claims, and/or lawsuits, pending or closed during the previous 10 years? ................................................................. Yes □ or □ No

Miscellaneous

1. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation? If yes please attach a detailed written explanation. ........................................................................................................................................... Yes □ or □ No

2. Have you ever been denied a professional license in any state? ........................................ Yes □ or □ No

3. Have you ever been requested to appear before any professional society? or licensing board because of a complaint or charge? .................................................. Yes □ or □ No

4. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? .......................................................... Yes □ or □ No

5. Have your hospital staff privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered or in any other way restricted, or have they been or are they currently under investigation? If "Yes," please attach a detailed written explanation................................................................. Yes □ or □ No

Applicant’s affidavit:

I certify that all the information contained in this application is correct 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.

Signature of Applicant: ___________________________________________ Date: _____________________