Geriatric Psychiatry
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 Geriatric Psychiatry 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.

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:

Ricky Snyder
Fellowship Coordinator
352-265-2863
dmchugh@ufl.edu

Uma Suryadevara, MD
Program Director
352-265-4357

University of Florida
Department of Psychiatry
4101 NW 89th Boulevard
Room 1782
Gainesville, FL 32606

Geriatric Psychiatry
Fellowship Application Form

Date of Application**: _____ Anticipated Start Date** for fellowship training: **_____**

Full Name: _____
Last **First** **Middle**

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** _____
(Foreign Nationals Only)

MDs: List USMLE dates and scores below:

USMLE **Step I** _____ _____USMLE **Step II** _____ _____
(Date) (Score) (Date) (Score)

USMLE **Step III** _____ _____
(Date) (Score)

DOs: List COMLEX Dates and Scores below:

Level 1 _____ Level 2 _____ Level 3 _____
(Date) (Score) (Date) (Score) (Date) (Score)

ECFMG Number and Date _____

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

_____

LICENSURE:

State _____ Number _____ Date _____ Type_____ Expiration Date _____

Educational Data

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

Start and End Dates: _____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Start and End Dates: _____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Graduate Education - (Medical and Masters or Doctoral Program)

Start and End Dates: _____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Start and End Dates: _____ to _____ List Degree awarded: _____

_____ _____
Institution Name 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 _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) 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 Geriatric Psychiatry 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: _____