

University of Connecticut  
Center on Aging



**Application For:** GERIATRIC MEDICINE FELLOWSHIP  
**To Begin:** July 20 \_\_\_\_\_

**PERSONAL DATA**

Name (Last, First, Middle)		Country of Citizenship	Social Security No.
Present Mailing Address Street:		Date of Birth:	Marital Status:
City:	State:      Zip:	Place of Birth:	No. of Dependents Living with you:
Phone: Day (    )	Evening (    )	Military Status:	Sex:
Cell phone: (    )	e-mail:		

**EDUCATION**

Schools and Address	Years From:	To:	Degree

**HOSPITALS WHERE INTERNSHIP, RESIDENCY, FELLOWSHIP TAKEN (INDICATE WHICH)**

Hospital	Type of Service	Years From:	To:	No. of Months

If Foreign Medical Graduate, fill in this row.	ECFMG Cert. #:	USMLE Scores 1:      2:      3:	Visa Type:	Visa #:      Expir Date:
--	----------------	---------------------------------	------------	--------------------------

**LIST HONORS, AWARDS AND PUBLICATIONS (USE SEPARATE SHEET IF NECESSARY)**


**INTERVIEW: GIVE DATES YOU ARE AVAILABLE**

--

**REFERENCES**

List at Least 3 Names, Titles, Addresses, and Phone Numbers (Program Director and at least 2 additional letters)

Have reference letters been requested? \_\_\_\_\_ YES \_\_\_\_\_ NO

**LICENSED TO PRACTICE IN:**

State:	Registration #	Date

**NATIONAL BOARD EXAMINATIONS**

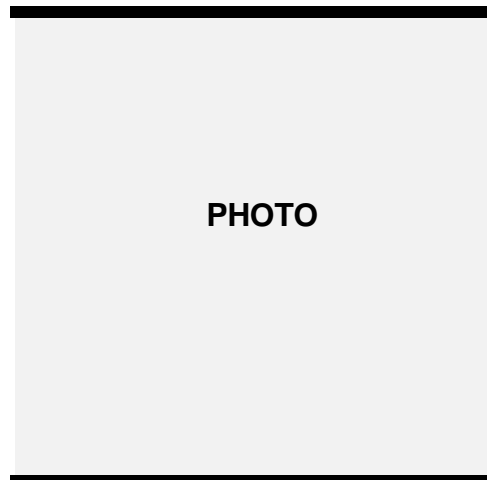
NBE	Pass?	Date

**STATE YOUR GOALS IN MEDICINE**

Please attach a 1-2 page statement on why you want to pursue a career in geriatrics and what you think you would like to be doing professionally 3-5 years after fellowship training.

**PLEASE FORWARD THIS FORM AND ALL OTHER CORRESPONDENCE TO:**

Gail M. Sullivan, MD, MPH  
Director, Geriatrics Fellowship Program  
University of Connecticut Center on Aging  
University of Connecticut Health Center  
Farmington, Connecticut 06030-5215  
Phone: (860) 679-3958



Signature of Applicant	Date Signed
------------------------	-------------