Penn Medicine

Department of Psychiatry
FELLOWSHIP IN COMMUNITY PSYCHIATRY

PHOTO

A RECENT PHOTOGRAPH (BLACK & WHITE PASSPORT SIZE) IS ACCEPTABLE

Personal Information

Full Name: ______________________________
Last *First* *M.I.*

Current Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: **( )** ______________ **Alternate Phone:** **( )** ______________

Permanent Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

E-mail Address: ______________________________

Social Security #: ______________ **Citizenship:** ______________

Date of Birth: ______________ **Place of Birth:** ______________

Emergency Contact: ______________________________

Address: ______________________________
Street Address Phone #

____
City *State* *ZIP Code*

Education

Degree (B.A., M.D., etc)	**University/College**	**Month/Year of Graduation**

Residency or Clinical Experience

Residency/Position	Hospital	City	Year

Board Certification: Yes: _______ No: _______ Discipline: ______________

Additional Information

Have you ever been denied a medical license or lost your license?

Yes _______ No _______ Reason: ______________________________

Have you ever resigned or been removed from a prior residency or fellowship program?

Yes _______ No _______ Reason: ______________________________

Have you ever been disciplined?

Yes _______ No _______ Reason: ______________________________

Have you ever been disciplined or dismissed from an appointment to medical school or residency or a professional employment?

Yes _______ No _______ Reason: ______________________________

Have you ever had medical licenses limited, restricted, suspended, revoked, denied, or have you been placed on probation or conditions?

Yes _______ No _______ Reason: ______________________________

Do you have any pending or previous professional misconducts?

Yes _______ No _______ Reason: ______________________________

Have you ever been convicted of a misdemeanor or a felony in any jurisdiction?

Yes _______ No _______ Reason: ______________________________

If you are ***not*** a United States citizen, and/or if you graduated from a foreign medical school, please complete the following:

Type of Visa: ______________________________

Do you intend to apply for U.S. Citizenship?

Yes _______ No _______ Reason: ______________________________

ECFMG Certificate Number:
Please attach a copy of the certificate. ______________________________

I certify the information contained in this application is complete and accurate to the best of my knowledge. I understand that my providing any false, missing, or misleading information may disqualify me for consideration for the Fellowship position.

Signature: ______________________________ **Date Submitted:** ______________

Attachments

With the application, please attach the following information:

1. A copy of your curriculum vitae.
2. A personal statement about why you wish to take this Fellowship (one page).
3. Two current letters of recommendation

Electronic submission of application materials is strongly preferred. All application documents may be forwarded electronically to Linda Ramos (lindara@pennmedicine.upenn.edu), subject line "Fellowship in Community Psychiatry." Please copy Larry Real (larry.real@hhinc.org) and Rachel Talley (Rachel.talley@hhinc.org) on your application submission. Letters of recommendation must be forwarded by faculty or their assistant's email to Linda Ramos, copying Larry Real and Rachel Talley.

Alternatively, applications can be submitted via regular mail. If regular mail is used, two (2) copies of the application must be sent.

Please submit application and attachments to:

Fellowship in Community Psychiatry c/o Linda Ramos
Perelman School of Medicine at the University of Pennsylvania
3535 Market Street – 2nd Floor, Suite 200
Philadelphia, PA 19104
215-746-7248 (office)
215-746-7203 (fax)

Please submit a 2nd copy of application and attachments to:

Horizon House, Inc. c/o Rachel Talley, M.D.
120 S. 30th Street
Mental Health Outpatient Program, 5th Floor
Philadelphia, PA 19104
215-386-3838 ext. 12122 (office)