



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 |
|--------------------------|--------------------|--------------------------|
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Residency or Clinical Experience

| Residency/Position | Hospital | City | Year |
|--------------------|----------|------|------|
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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 participate in this Fellowship (one page).
3. Letter of Recommendation from Residency Director plus one additional Letter 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@pennmedicine.upenn.edu) 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)