

Geriatric Psychiatry Fellowship Application

Demographics

Date of application:

For training beginning in:

Full name:

Last

First

Middle

Present mailing address:

Street

Street 2

City/State/Zip

Permanent mailing address:

Street

Street 2

City/State/Zip

Phone: Home

Work

Cell

Email

Place of birth

Legally eligible to work in USA?!

Yes

No

Visa status (if foreign national)

NRMP Participant Code

Current PGY year (or already graduated)

Certification/ Licensure/ References

Certification

USMLE (MD applicants)

Step I: Passed? Yes No Date passed: Score:

Step II: Passed? Yes No Date passed: Score:

Step III: Passed? Yes No Date passed: Score:

COMLEX (DO applicants)

Level I: Passed? Yes No Date passed: Score:

Level II: Passed? Yes No Date passed: Score:

Level III: Passed? Yes No Date passed: Score:

ECFMG number (if applicable): Date: Not applicable

Board-certified? Yes No

If "yes" enter name of Board and year certified:

Licensure (primary)

Licensure: State: Number: Type:

Orig lic date: Exp date:

References

Please have at least three and no more than four letters of recommendation from professionals with whom you have worked and/or studied. One of these letters must be from your current or most recent Program Director. Have the letters sent directly to:

Azziza Bankole, M.D.
[Geriatric Psychiatry](#) Fellowship Director
2017 Jefferson Street SW
Roanoke VA 24014

Please list these references below:

Ref 1:

Ref 2:

Ref 3:

Ref 4:

Education

Undergraduate: (please provide full name and mailing address for all schools listed)

School 1:

Address: Street:

Address: City: State/Country: Zip:

Dates attended: to Degree awarded:

School 2:

Address: Street:

Address: City: State/Country: Zip:

Dates attended: to Degree awarded:

Graduate (medical, doctoral, or masters): (please provide full name and mailing address for all schools listed)

Institution 1:

Address: Street:

Address: City: State/Country: Zip:

Dates attended: to Degree awarded:

Institution 2:

Address: Street:

Address: City: State/Country: Zip:

Dates attended: to Degree awarded:

Are there further institutions? Yes No . If so please provide information on a separate sheet.

Postgraduate: (please provide full name and mailing address for all schools listed)

Separate Internship: Yes No . If yes, institution:

Address: Street:

Address: City: State/Country: Zip:

Dates attended: to ACGME accredited? Yes No .

Education (continued)

General Psychiatry Residency:

Address: Street:

Address: City:

State/Country:

Zip:

Dates attended: to

ACGME accredited? Yes No .

Fellowships:

Address: Street:

Address: City:

State/Country:

Zip:

Dates attended: to

ACGME accredited? Yes No .

Are there further fellowships? Yes No . If so please provide information on a separate sheet.

Other professional training

Nature of training:

Institution:

Dates attended: to

Other Experience

Relevant work experience:

Research experience and/or interests:

Publications/Presentations at scientific meetings:

Honors/ Awards:

Professional memberships:

Outside interests/ Achievements:

Personal Statement

Please describe your interest in addiction psychiatry and plans for future professional work.
(1000 word limit):

I attest that the Attestation/Affidavit signed on a separate sheet applies to this application.

Signature

Date