UCLA Geriatric Psychiatry
Fellowship Application Requirements

Eligible candidates will have completed an ACGME–accredited psychiatry residency program prior to start date of the fellowship.

The following documents will be necessary to process your application:

- Application
- Curriculum Vitae
- Personal Statement *(Please describe your interests, achievements, and career goals.)*
- Dean's Letter *(Official copy required.)*
- Medical School Transcript *(Official transcripts required.)*
- USMLE I, II, III Scores *(Original transcripts required.)*
- Residency Director's Letter
- ECFMG Certificate, if applicable
- 3 Letters of Recommendation
- Privacy Act Waiver

Applications and questions about the application process or fellowship should be directed to:

Ron Lopez
Housestaff Coordinator
UCLA Department of Psychiatry
760 Westwood Plaza, 37-357
Los Angeles, CA 90024
Phone: (310) 825-0018
Fax: (310) 825-6483
Email: ronaldlopez@mednet.ucla.edu

UCLA Geriatric Psychiatry Fellowship
Application Form

Date of Application**:** _____

Requested Year: _____

Full Name: _____
Last First Middle

Present Mailing Address:

_____

_____

Permanent Mailing Address:

_____

_____

Current PG Yr. _____

Telephone: Home _____ Work _____ Cell _____

Email: _____

Place of Birth _____

Legally eligible to work in USA? _____ Visa Status (if foreign national) _____

Service payback obligations? If "yes" please describe _____

_____

Passed					
USMLE Step I	_____	(Date)	_____	(Score)	
USMLE Step II	_____	(Date)	_____	(Score)	
USMLE Step III	_____	(Date)	_____	(Score)	
Passed					
COMLEX (for DO training)	Level 1 _____ (Date)		Level 2 _____ (Date)		Level 3 _____ (Date)

ECFMG number /date _____

Board Certified? If "yes" enter name of board and year certified _____

LICENSURE: State _____ Number _____ Date _____ Type _____ Expiration _____

DEA NUMBER:_____

LETTERS OF REFERENCE ARE EXPECTED FROM THE FOLLOWING:

1. Director(s) of Psychiatry Residency

Name: _____

Program Name: _____

Phone Number: _____

2. Director of Internship

Name: _____

Program/Hospital Name: _____

Phone Number: _____

3. **Dean of Medical School**

Name: _____

School Name: _____

Phone Number: _____

4. **Professional References**

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Educational Data

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

_____ _____
Institution Address

Attended from: _____ to _____ Degree awarded: _____

_____ _____
Institution Address

Attended from: _____ to _____ Degree awarded: _____

Graduate Education (Medical and Masters or Doctoral Program)

_____ _____
Institution Address

Attended from: _____ to _____ Degree awarded: _____

_____ _____
Institution Address

Attended from: _____ to _____ Degree awarded: _____

Postgraduate Medical Education:

Internship: (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited Yes ☐ No ☐
Address

Residencies: (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited Yes ☐ No ☐

Address

Fellowships: (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited Yes ☐ No ☐

Address

Other Professional training:

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

Address: _____ ACGME Accredited Yes ☐ No ☐

Work and Research Experience

Relevant Work Experience:

Research Experience and/or Interests:

Publications/Presentations at scientific meetings Yes No (Please list)

Honors / Awards:

Professional Memberships:

Outside Interests / Achievements:

Training Documentation Form

(To be completed by the current Program Director)

Date: _____

To: UCLA Geriatric Psychiatry Fellowship Training Program

From: _____
(Program Director)
Residency Training Program:_____

Re: _____
(Applicant)

This is to verify that Dr. _____entered our program as a PG_____ on _____. By (date) _____ he/she will have satisfactorily completed the following training.

____ FTE months of primary care: internal medicine, pediatrics, family practice (4 months minimum)

____ FTE months of neurology (2 months minimum; one month may be child neurology)

____ FTE months of adult inpatient psychiatry (6 FTE months)

____ FTE months of adult outpatient psychiatry (12 FTE months, of which a minimum of 20% must be continuous experience)

____ FTE months of child and adolescent psychiatry (1 month minimum, in– or outpatient)

____ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child C-L)

____ FTE months of geriatric psychiatry (1 month minimum, in– or outpatient)

____ FTE months of addiction psychiatry (1 month minimum, in- or outpatient)

____ Psychotherapy competencies

He/She has successfully completed the following Interviewing Clinical Skills Verification (CSV) Evaluations:
1. Date_____ 2. Date_____ 3. Date _____

He/She has had/will have experience by (date) _____ in (please check):
community psychiatry forensic psychiatry
emergency psychiatry ECT

The following general psychiatry requirements will not be completed by (date) _____
_____.

Signature of Program Director: _____

Please return completed form to:
Ron Lopez, Housestaff Coordinator
Geriatric Psychiatry
760 Westwood Plaza, Room 37-357
Los Angeles, CA 90024

Date _____

Personal Statement

Please describe your interest in Geriatric Psychiatry and plans for future professional work. (1,000-word limit)

Attestations

A. Malpractice

If there have been settlements, malpractice claims, and/or lawsuits pending or closed during the previous 10 years, please describe on a separate page.

B. Miscellaneous

a. Has your professional license in any state ever been revoked, suspended, canceled or restricted
Yes ☐ No ☐

b. Have you ever been denied a professional license in any state? Yes ☐ No ☐

c. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge? Yes ☐ No ☐

d. 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 ☐ No ☐

e. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason?
Yes ☐ No ☐

f. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? Yes ☐ No ☐

g. Have you ever been convicted of a felony in a criminal action? Yes ☐ No ☐

Important: If you answered "Yes" to any of the above questions, please attach a written explanation.

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:_____

WAIVER OF ACCESS TO LETTERS OF REFERENCE

The Family Educational Rights and Privacy Act of 1974 assures students access to any material in the files of their institution that pertains to them, including letters of reference obtained when they first applied for admission. Because persons writing letters of recommendation frequently assume that their letters will be held in confidence (so that they can be fully candid), awkward or embarrassing situations might occasionally arise between accepted applicants and those writing letters of reference. Therefore, in order to be fair both to applicants and persons from whom letters of recommendation are requested, the Regents of the University of California have urged all departments in the University to request (but not require) that applicants sign the waiver that appears below. While letters written "in confidence" may be more helpful in our assessment of an applicant's qualifications and abilities, all letters are carefully considered.

Please indicate your choice regarding your access to letters of recommendation by signing beneath one of the statements below.

1. I understand that letters of recommendation concerning me are to be written and maintained in confidence, and I expressly waive any rights I might have to access such letters under the Family Educational Rights and Privacy Act of 1974, or any other law, regulation or policy.

DATE: _____ SIGNATURE: _____

PRINT NAME: _____

2. I do not agree to this waiver.

DATE: _____ SIGNATURE: _____

PRINT NAME: _____

APPLICATION AND INTERVIEWING INFORMATION

1. PLEASE SPECIFY A WEEK (MONDAY-FRIDAY), FROM OCTOBER 1 THROUGH DECEMBER 15 WHEN YOU WILL BE ABLE TO COME TO LOS ANGELES FOR INTERVIEWS:

_____

2. FAX # OR EMAIL ADDRESS TO WHICH CONFIRMATION AND ITINERARY CAN BE SENT APPROXIMATELY 3 BUSINESS DAYS BEFORE YOUR APPOINTMENT:

_____

3. ARE YOU INTERESTED IN A TWO-YEAR GERIATRIC PSYCHIATRY ACADEMIC FELLOWSHIP POSITION? (IF YOU ARE INTERESTED IN THE RESEARCH TRACK, PLEASE MAKE SURE TO INCLUDE A DESCRIPTION OF YOUR RESEARCH INTERESTS IN YOUR PERSONAL STATEMENT**.)**

_____

4. YOU MAY EMAIL THE APPLICATION FORM AND CURRICULUM VITAE TO
ronaldlopez@mednet.ucla.edu
PLEASE MAIL THE DOCUMENTS LISTED BELOW TO:

Ron Lopez
Geriatric Psychiatry Housestaff Coordinator
Department of Psychiatry
760 Westwood Plaza, Room 37-357
Los Angeles, CA 90024

- Dean's Letter
- Medical School Transcript *(Original transcripts required.)*
- Board Scores *(Original transcripts required.)*
- Residency Director's Letter
- ECFMG Certificate, if applicable*
- 3 Letters of Recommendation
- Privacy Act Waiver
- Photograph *(Passport style preferred; for identification purposes only. You may also email in an electronic version)*

*If you did not graduate from a US Medical School you also need to include a copy of a California Medical license or California Status letter, and your ECFMG Certification. If you are in the US on a J-1 visa, please include a copy of your passport, your I-94 and your IAP-66. If you don't have the California Status Letter, please call the Medical Board of California at (916) 263-2499 for information on this item.