UCLA Forensic 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, how you became interested in forensic psychiatry, career goals, and why you are interested in the UCLA program.)
- 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
- Writing sample of treatment or forensic case
- Sample published papers if any
- Privacy Act Waiver

Applications and questions about the application process or fellowship should be directed to:
Dulce Madrid - Program Coordinator
DMadridGonzalez@mednet.ucla.edu
Subject: Application - Forensic Psychiatry Fellowship

Mailing Address:
UCLA Psychiatry Office of Education
Forensic Psychiatry Fellowship Program
760 Westwood Plaza
Room 37-384
Los Angeles, CA 90024
UCLA Forensic 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 Level 1 ___________ (Date) Level 2 ___________ (Date) Level 3 ___________ (Date)

(for DO training)

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: _______________________________________

Name: _____________________________________________
Phone Number: _______________________________________
## Educational Data

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

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<th>Institution</th>
<th>Address</th>
<th>Attended from: to</th>
<th>Degree awarded:</th>
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**Graduate Education (Medical and Masters or Doctoral Program)**

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**Postgraduate Medical Education:**

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

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<th>Specialty</th>
<th>From (Month/Day/Year)</th>
<th>To (Month/Day/Year)</th>
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<th>Yes</th>
<th>No</th>
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### Residencies:
(if more than one, please provide additional information on a separate sheet)

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

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### Other Professional training:

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<th>ACGME Accredited</th>
<th>Yes ☐ No ☐</th>
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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)

To: UCLA Forensic 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: ____________________________
Personal Statement
Please describe your interest in Forensic 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 WHEN YOU WILL BE ABLE TO COME TO LOS ANGELES FOR INTERVIEWS:

2. EMAIL ADDRESS TO WHICH CONFIRMATION AND INTERVIEW ITINERARY CAN BE SENT TO:

3. PLEASE EMAIL OR MAIL THE DOCUMENTS LISTED BELOW TO:
   Dulce Madrid - Program Coordinator:
   DMadridGonzalez@mednet.ucla.edu

   Mailing Address:
   UCLA Forensic Psychiatry Fellowship
   Psychiatry House Staff Office
   UCLA Semel Institute for Neuroscience and Human Behavior
   760 Westwood Plaza, Rm 37-384
   Los Angeles, CA 90024

   • Dean’s Letter
   • Medical School Transcript (Original transcripts required.)
   • Board Scores (Original transcripts required.)
   • Residency Director’s Letter (separate from 3 letters of recommendation)
   • 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.