
PHOTO

(2" X 2")

**The University of Texas Medical Branch
Department of Internal Medicine
Division of Geriatric Medicine
Galveston, Texas 77555-0460**

Please Attach Photograph
With Your Signature
On the Front Surface

***YEAR APPLYING FOR** _____

PLEASE TYPE OR PRINT FULL INFORMATION AS APPLICABLE (use additional sheets when necessary):

Full Legal Name: _____
Last First Middle

Current Address: _____
Number and Street City State Zip

Telephone(s): _____
(Area Code) Home Number (Please also include a cellular or pager number)

Permanent Address: _____
Number and Street City State Zip

Social Security Number: _____ Citizenship: _____

If NOT U.S. Citizen, Visa Status: _____

Birth date: _____ Birthplace: _____

Prior Military Service or Obligation? Yes No If yes, Please Explain: _____

Premedical Training: _____ City: _____

Main Field(s) of Study: _____ Degree(s) and Year(s): _____

Medical School: _____ City: _____

Date of Graduation: ___ / ___ / ___ Degree: _____ State/Country: _____

Internship: _____ Dates: _____
(Hospital and City)

Residencies/
Fellowships: _____
(Type) (Hospital and City) (Dates)

APPLICATION FOR FELLOWSHIP/PAGE 2

Other postgraduate education (with dates): _____

Membership in Medical Societies, Professional Organizations, Honorary Societies:

Awards, Honors, Publications: _____

Outside Interests: _____

Research experience and interests in Geriatrics/Gerontology: _____

Clinical experience and interests in Geriatric Medicine: _____

Career goals (How will you use your Geriatrics training?): _____

APPLICATION FOR FELLOWSHIP/PAGE 3

If Foreign Medical Graduate, ECFMG #: _____

Certification by Federal Licensing Examination (FLEX)? Yes No Date: _____

Certification by National Board of Medical Examiners? Yes No Date: _____

Certification by Texas State Board Examination? Yes No Date: _____

Certification by American Specialty Board? Yes No Date: _____

Board: _____

USMLE for students/graduates of foreign medical schools:

Please enter number of times taken for each Step:

STEP 1: Number of Times Taken: _____ Date Taken: __/__/__ Date Passed: __/__/__

STEP 2: Number of Times Taken: _____ Date Taken: __/__/__ Date Passed: __/__/__

STEP 3: Number of Times Taken: _____ Date Taken: __/__/__ Date Passed: __/__/__

Names of References, Titles, and Addresses:

1. _____

2. _____

3. _____

Supporting Materials Required:

1. **A curriculum vitae.**
2. **Copies of your USMLE scores.**
3. **Personal Statement**
4. **Three letters of recommendation (one must be from your Program Director) addressed to Anita C. Mercado, M.D. Do not include letters with application instead have letters sent directly to program at address below.**

**MAIL APPLICATION AND LETTERS OF RECOMMENDATION TO:
RHONDA BAILES
COORDINATOR, GERIATRIC FELLOWSHIP PROGRAM
DIVISION OF GERIATRIC MEDICINE
UNIVERSITY OF TEXAS MEDICAL BRANCH
301 UNIVERSITY BOULEVARD
GALVESTON, TEXAS 77555-0460**