Joan and Sanford I. Weill Medical College of Cornell University
Fellowship Program in Clinical Epidemiology and Health Services Research

1300 York Avenue Street, Box #46
New York, NY 10065, USA
Tel: (212) 746-1608 Fax: (212) 746- 7443

APPLICATION FOR ADMISSION

Application deadline: May 1

The program is open to physicians who have completed an accredited residency training program in any clinical area. The program is open to United States Citizens and non-citizen nationals of the United States. Applicants must provide proof of citizenship or permanent residence.

Applicants for admission must be graduates of an approved college or university and must show evidence of fitness for advanced work as indicated by their scholastic records, training, and experience.

All documents, including translations of documents, must be official, i.e., must bear original signatures and seals. Do not fax application form or supporting documents; only correspondence can be faxed. No final action can be taken on applications until the following supporting documents have been reviewed:

- **Complete official transcripts** of all previous college and university work, including summer schools. A *final* transcript must be supplied after the completion of current degree requirements.

- **Three letters of recommendation** from professors or other professionals with knowledge of the applicant's abilities in the areas of academic aptitude and achievement and/or in carrying out professional work and responsibilities.

- ***Official* GRE score reports** (Verbal, Quantitative, Analytical and Advanced); *Official* MCAT score reports (Verbal, Quantitative, Analytical and Advanced); *Official* TOEFL score report if English is not native language. These reports must be sent *directly* to the Graduate School of Medical Sciences by the Educational Testing Service, Princeton, NJ. (*If the applicant has an M.D. degree – this requirement is waived*.)

- **A personal statement**: Please provide a concise description of your research experience and research interests. (Your essay should not exceed one typed page, single-spaced, and using a font not smaller than 12 points.)

- **An updated curriculum vitae.**

Please mail this application and have all supporting materials forwarded to the address above.

APPLICATION FORM

Note: Program begins July 1

Proposed year of admission:_____

PERSONAL INFORMATION

Please type or print clearly.

Name _____ _____ _____
Last First Middle Initial

Social Security Number _____ Sex ○ Male ○ Female

Permanent Mailing Address: _____
Street

_____ _____
City, State, Zip Country

Daytime Telephone:_____ Evening Telephone:_____

Present Address (if different):

_____
Street City, State, Zip Country

E-mail address: _____

Place of birth: _____ Date of Birth _____

Citizenship: _____

Number of dependents: ____

Name of spouse/significant other:

_____ _____ _____
Last First Middle

In case of emergency, notify (name, relationship, contact information):

_____

_____

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What is your racial background? *Check one or more*

- ☐ Do Not Wish to Provide
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Hispanic (or Latino)

Are you a United States citizen? ◯ Yes ◯ No

If no, are you a U.S. national (do you have a green card?) ◯ Yes ◯ No
If yes, please provide documentation.

Are you a graduate of a foreign medical school (except Canada): You are required to be certified by the Educational Council for Foreign Medical Graduates.

If you are certified, indicate below: (Photocopy must be enclosed)

Standard Certificate: _____
number

Interim certificate: _____
number

Date of passing ECFM exam: _____
Month Date Year

RESEARCH AND CAREER PLANS

Please indicate which research areas you are interested in (check all that apply):

- ☐ Translating Research into Practice and Policy
- ☐ Patient Safety and Quality
- ☐ Quality Improvement
- ☐ Health Care Disparities
- ☐ Patient-Centered Care
- ☐ Core Competencies
- ☐ Payment, Markets and Organization
- ☐ Large-Scale Database Methods

Do you plan to take a subspecialty fellowship in the future? ◯ Yes ◯ No

Please specify: _____

Do you plan to earn any further degrees in the future? ◯ Yes ◯ No

Please specify: _____

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PRELIMINARY INQUIRY

Please type or print clearly.

1. Describe your research interests:

2. Describe the position you think you would want after completing the Fellowship Program:

3. Describe your long-term goals:

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4. The usual period of time for a Fellow to be associated with the Program is two years. If you will require more or less time, please explain why.

5. If you wish, provide any additional information that may be helpful to the Selection Committee.

6. If you have published, please list your publications (books, monographs, and/or articles). Please indicate the single publication which represented your best work. You may attach a list of your publications if one is already typed. Abstracts and publications should be separated.

REFERENCES

Please arrange to have three letters of reference submitted promptly. One must be from the Director of your current or most recent clinical training program. List the three referring faculty members from whom we can expect to hear:

name	address	title	phone
name	address	title	phone
name	address	title	phone
name	address	title	phone

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THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS REQUIRES ALL REMAINING QUESTIONS TO BE ANSWERED:

STATE OF HEALTH

Present state of health: _____ Date of last physical examination: _____

Significant findings: _____

_____

Name and address of physician and/or institution where physical examination performed:

_____

Name of Physician Name of Institution

_____

Address (Street, City, State, Zip)

Dates and causes of all hospitalizations for prior five years: _____

_____

Physical disabilities or limitations: _____

_____

Have you ever been convicted of a felony?

◯ Yes ◯ No

If yes, explain: _____

_____

_____

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EDUCATION, LICENSURE AND EXPERIENCE

EDUCATION

High School, College, Post Graduate, Medical

Name of Institution and Location	Degrees Received (List from most recent)		Major/ Minor/ Field
	Degree	Month/Year	

Honors (if any): _____

_____

Internships

List from most recent:

Hospital	Location	Dates	Type

Residencies

List from most recent:

Hospital	Location	Dates	Type

Fellowships

List from most recent:

Hospital/Institution	Location	Dates	Type

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Board and/or Subspecialty Board Certified: _____

Have your privileges at any hospital or other facility ever been denied, limited, suspended, revoked or not renewed? And/or have you ever been denied membership or a renewal therein or been subjected to disciplinary proceedings in any hospital or medical organizations?

◯ Yes ◯ No

If yes, provide full details on separate sheet.

Licensures

List from most recent:

Jurisdiction	Date Issued	License #

Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?

◯ Yes ◯ No

If yes, provide full details on separate sheet.

Are any of your licenses currently limited or temporary?

◯ Yes ◯ No

If yes, provide details: _____

_____

_____

National and State Board Examinations

List from most recent:

Date	State	Number	Result

Signature

_____ _____

Signature of Applicant Date

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