

**Albert Einstein College of Medicine  
Montefiore Medical Center  
111 East 210<sup>th</sup> Street  
Bronx, NY 10467**

**APPLICATION FOR APPOINTMENT TO PALLIATIVE MEDICINE  
FELLOWSHIP TRAINING**

**Instructions: Please type or print application clearly**

1. Please fill out all portions of this application and attach a recent photograph.
2. The following credentials are required for each application:
  - a. *Letter from current Program Director*
  - b. *2 Additional letters of recommendation*
  - c. *Personal statement reflecting the candidate's interest in Palliative Care.*
  - d. *Photo*
  - e. *CV*
  - f. *Copy of Medical School Diploma*
  - g. *Copy of Diploma of completed graduate medical education*
  - h. *Copy of Reports from Medical Board Exams*
3. Send copies of application and have letters sent to:  
**Lisa Zelnick, MD, Palliative Care Service, 3347 Steuben Avenue, Second Floor, Bronx, NY 10467.**

*\*Indicate year for which you are applying: \_\_\_\_\_*

**PERSONAL :**

Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Last First Middle

Birth date \_\_\_\_\_ Birthplace \_\_\_\_\_ US Citizen \_\_\_yes\_\_\_no

Present Address \_\_\_\_\_  
Number and Street City State Apt. No. Zip Code

Home Telephone Number ( ) \_\_\_\_\_

Permanent Address \_\_\_\_\_  
Number and Street City State Apt. No. Zip Code

Telephone Number ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**EDUCATION:** College and Medical School List all schools beginning with Medical School and ending with College

<u>Institution</u>	<u>Dates of Attendance</u>	<u>Degree and Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PROFESSIONAL EXPERIENCE**

**Internship:** Hospital \_\_\_\_\_ Dates From \_\_\_\_\_ To \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

**Residency:** Hospital \_\_\_\_\_ Dates From \_\_\_\_\_ To \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

**Residency:** Hospital \_\_\_\_\_ Dates From \_\_\_\_\_ To \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

**PGY Year:** \_\_\_\_\_

**RESEARCH EXPERIENCE:** (Include Publications Where Applicable)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HONORS, AWARDS, HONORARY SOCIETIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL LICENSURE:**

State \_\_\_\_\_ Number \_\_\_\_\_ Date of Issue \_\_\_\_\_ Expiration \_\_\_\_\_

**INTERNATIONAL MEDICAL GRADUATES:**

**Certification:** (Check one and enter required information)

- \_\_\_\_\_ 1. Certification by National Board of Medical Examiners Date \_\_\_\_\_
- \_\_\_\_\_ 2. Standard ECFMG Certificate Number \_\_\_\_\_ Expiration Date \_\_\_\_\_
- \_\_\_\_\_ 3. ECFMG Exam: Part I Score \_\_\_\_\_ Part II Score \_\_\_\_\_  
English \_\_\_\_\_ Pass \_\_\_\_\_ Fail \_\_\_\_\_
- \_\_\_\_\_ 4. Temporary ECFMG: Certificate Number \_\_\_\_\_

**Type of Visa** (Check one)

- \_\_\_\_\_ Permanent Resident
- \_\_\_\_\_ J-1 Visa
- \_\_\_\_\_ F-1 Visa
- \_\_\_\_\_ H-1 Visa
- \_\_\_\_\_ Refugee/Displaced Person
- \_\_\_\_\_ Other (Explain)

**LETTERS OF RECOMMENDATION:**

**1. Program Director**

Name \_\_\_\_\_

Phone and Email \_\_\_\_\_

**2. Reference Letter**

Name \_\_\_\_\_

Phone and Email \_\_\_\_\_

**3. Reference Letter**

Name \_\_\_\_\_

Phone and Email \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_