

# Common Application for Consultation-Liaison Psychiatry Fellowship

(This application form was prepared by the Academy of Consultation-Liaison Psychiatry)

Items marked with an \* are optional

Please attach recent photo\*

- Please include:
1. Completed application form
  2. Curriculum vitae
  3. Letter from Residency Training Director
  4. Two additional letters of recommendation
  5. Personal statement describing your current interests, accomplishments, and professional goals in Consultation-Liaison Psychiatry

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Position Desired: PGY-V  PGY-VI  Starting: \_\_\_\_\_, 20\_\_\_\_  
Month Year

Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Current Address: \_\_\_\_\_  
Street

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Current Home/Cell Phone: \_\_\_\_\_ Current Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth Date\* (mm/dd/yyyy): \_\_\_\_\_ Race/Ethnicity\*: \_\_\_\_\_ Gender\*: \_\_\_\_\_

Citizenship: Type of visa (non-US citizens): \_\_\_\_\_

## Undergraduate Education:

Name of School: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_ Degree: \_\_\_\_\_

Name of School: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_ Degree: \_\_\_\_\_

## Medical School:

Name of School: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_ Degree: \_\_\_\_\_

Name of School: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_ Degree: \_\_\_\_\_

## Other Postgraduate Education:

Name of School: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_ Degree: \_\_\_\_\_

Name of School: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_ Degree: \_\_\_\_\_

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Residency Program:

Name of Program: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_  
Name of Program: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_

Clinical Experience in addition to Residency (include internships and other pertinent training with the institution name and dates of attendance):

USMLE Exam Scores: Step I: \_\_\_\_\_ Step II: \_\_\_\_\_ Step III: \_\_\_\_\_

Foreign Medical Graduates:

A copy of the standard ECFMG certificate must accompany the application.  
ECFMG No. (if applicable): \_\_\_\_\_

Board Certified?  Yes (year: \_\_\_\_\_)  No

State Medical License (if applicable): \_\_\_\_\_  
Year State License No.

Letters of Recommendation will be sent by:

1. Name: \_\_\_\_\_ Title: \_\_\_\_\_ (Training Director)  
Address: \_\_\_\_\_
2. Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_
3. Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_

Date of Application: \_\_\_\_\_ Signature: \_\_\_\_\_