JOHNS HOPKINS
MEDICINE
SCHOOL OF MEDICINE

APPLICATION FOR APPOINTMENT TO HOPKINS ACADEMIC HOSPITALIST FELLOWSHIP PROGRAM

Johns Hopkins Bayview Medical Center
5200 Eastern Avenue
MFL East Tower, 2nd Floor
Baltimore, MD 21224

Instructions for Completion of this Application

- Complete all sections, either clearly print or type all responses.
- If a section does not pertain to you, mark as N/A (not applicable). Do not leave any section blank. Each section must be complete and legible or your application will be deemed incomplete and returned to you. This also pertains to any attachment you include with the application.
- Do not refer to an enclosed curriculum vitae in lieu of completing a section.
- The processing of your application will not begin until a completed application has been received.
- All chronology must be accounted for from the completion of your medical professional degree to the present. Gaps of one month or more will cause the verification process to be delayed until you provide an explanation. Delays can also be caused by incomplete names and addresses – please provide complete information in all sections.
- If additional space is needed, place this information on the provided Continuation Page. You may make additional copies of this page if necessary. Keep these additional pages in sequence with corresponding application pages.

Completed Applications should be sent to:
Tiffani M Panek, Program Coordinator
Via Email: tpanek1@jhmi.edu
or
Via Fax: 410-550-2972 (fax)
or
Via FedEx/UPS:
Johns Hopkins Bayview Medical Center
5200 Eastern Avenue, Division of Hospital Medicine Suite
Mason F. Lord Bldg, MFL East Tower, 2nd Floor
Baltimore, MD 21224

**** DO NOT SEND VIA REGULAR POSTAL SERVICE (USPS) ****

Applicant's Name - Last: _____ First: _____ Middle: _____

SECTION A: DEMOGRAPHICS

1. Name: _____ (Last / First / Middle)

2. Other Name Used: _____ (Last / First / Middle)

3. Social Security Number: _____

4. Current Local Address (include street, city, state and zip):

_____

5. Current Local Telephone Number: _____

6. Permanent Address (include street, city, state and zip):

_____

7. Email Address: _____

8. Emergency Contact: _____ (Name / Telephone Number(s) / Relationship to Candidate)

SECTION B: CITIZENSHIP

1. Are you a Citizen of the United States _____ Yes _____ No **If no, complete the following:**

2. Country of Citizenship _____ 3. Visa Type _____

4. Entrance Date into U.S.: _____ 5. Length of Stay Valid to: _____

6. Do you have permission to work? _____ Yes _____ No

7. Is your degree of patient care involvement limited by your visa? Yes No

Applicant's Name - Last: _____ First: _____ Middle: _____

SECTION C: COLLEGE(S) ATTENDED (undergraduate education):

1. Name of School: _____

Mailing Address: _____

Months/Years Attended: _____ Degrees Conferred: _____

_____

(Use continuation sheet , Page 8, if necessary)

SECTION D: PROFESSIONAL EDUCATION (medical school or other doctoral program):

1. Name of School: _____

2. Mailing Address: _____

3. Months/Years Attended: _____ 4. Degrees Conferred: _____

(Use continuation sheet , Page 8, if necessary)

SECTION E: For International Medical School graduates:

ECFMG No: _____ Valid to: _____ (provide copy of your certificate)

Applicant's Name - Last: _____ First: _____ Middle: _____

SECTION F: INTERNSHIPS, RESIDENCIES, OTHER POSTDOCTORAL TRAINING & FELLOWSHIP PROGRAMS:

1. Name of School: _____

Mailing Address: _____

Months/Years Attended: _____ Service or Subject: _____

2. Name of School: _____

Mailing Address: _____

Months/Years Attended: _____ Service or Subject: _____

3. Name of School: _____

Mailing Address: _____

Months/Years Attended: _____ Service or Subject: _____

(Use continuation sheet , Page 8, if necessary)

SECTION G: NATIONAL BOARD OF MEDICAL EXAMINERS:

1. Diploma: _____ Yes (attach copy) Date: _____

2. Board Scores for NBME: Part I: _____ Part II: _____

3. USMLE Scores: Step I: _____ Step II: _____ Step III: _____

4. Clinical Skills Assessment Test Score: _____

Applicant's Name - Last: _____ First: _____ Middle: _____

SECTION H: CURRENT POSITION AND/OR SCIENTIFIC ACTIVITIES:

SECTION I: HOSPITAL APPOINTMENTS (other than what is included in your training program): List chronologically your appointments to other hospital staffs.

1. Name of Hospital: _____

Mailing Address: _____

Dates of Appointment: _____ Types of Appointment: _____

2. Name of Hospital: _____

Mailing Address: _____

Dates of Appointment: _____ Types of Appointment: _____

(Use continuation sheet , Page 8, if necessary)

Applicant's Name - Last: _____ First: _____ Middle: _____

SECTION J: TEACHING APPOINTMENTS (other than what is included in your training program): List chronologically any teaching appointments.

1. Name of Institution: _____

Mailing Address: _____

Dates of Appointment: _____ Types of Appointment: _____

2. Name of Institution: _____

Mailing Address: _____

Dates of Appointment: _____ Types of Appointment: _____

(Use continuation sheet , Page 8, if necessary)

SECTION K: Please explain any gaps in time / interruptions in clinical training and/or appointments since receipt of medical or professional degree. **Any gap of one month or more must be explained.**

SECTION L: LICENSURE
List any health occupation license or registration ever held, showing state(s), country(s), number(s), date(s), and status.

SECTION M: Member or Fellow of (e.g. AMA, ACP, etc): List all past or present memberships

SECTION N: Publications (you may attach a list in lieu of listing here):

Applicant's Name - Last: _____ First: _____ Middle: _____

SECTION O: Awards and Honors Received:

SECTION P: Languages Spoken:

SECTION Q: LETTERS OF RECOMMENDATIONS & REFERENCES

Please attach to this application Letters of Recommendation from your residency program director as well as three (3) other physicians who have worked extensively with you or have been responsible for professional observation of you. Do not use: relatives by blood or marriage, the Chief of Service to which you are applying, persons in current training program with you, nor persons who cannot attest to your current level of clinical competency, technical skill and medical knowledge.

Below, please list the contact information for the references giving these Letters of Recommendation.

1. Residency Director:
Name: _____

Mailing Address: _____

Daytime Telephone #: _____ Fax #: _____ Email: _____

2. Physician Reference #1:
Name: _____

Mailing Address: _____

Daytime Telephone #: _____ Fax #: _____ Email: _____

3. Physician Reference #2:
Name: _____

Mailing Address: _____

Daytime Telephone #: _____ Fax #: _____ Email: _____

4. Physician Reference #3:
Name: _____

Mailing Address: _____

Daytime Telephone #: _____ Fax #: _____ Email: _____

Applicant's Name - Last: _____ First: _____ Middle: _____

SECTION R: ACADEMIC HOSPITALIST INTERESTS

Please attached to this application a 1-2 page letter of purpose. This letter should include, but not be limited to, the following:

- Your reasons for applying for the Hopkins Academic Hospitalist Fellowship Program
- Your goals for the fellowship program, as well as your long-term career goals
- Your specific interests in the field of academic hospital medicine (clinical, leadership, education, research, etc)
- Any training, experiences, etc which you think set you apart as uniquely suited for acceptance into the Fellowship Program

The letter of purpose must be typed in 12pt font, double spaced, with 1 inch margins.

SECTION S: ATTACHMENTS

Please attached to this application copies of the following (some items have been previously mentioned):

- Current CV
- Copy of front and back of Permanent Residency Card or EAD, if applicable
- Copy of ECFMG Certificate if applicable, and copies of all other diplomas, certifications, etc.
- Copy of NBME/USMLE scores as applicable
- Copy of any current licensure
- Copy of any articles/abstracts
- Three letters of recommendation, including one from your current Program Director (letter do not have to be sealed originals – faxed or scanned copies of signed letters, on letterhead, will suffice)
- 1-2 Page Statement of Purpose

Applicant's Name - Last: _____ First: _____ Middle: _____

CONTINUATION PAGE: Use this page to document additional information. Make additional copies of this sheet as necessary and attach all copies to the application. Please be sure to indicate which Section Letter and question number you are continuing here.

Applicant's Name - Last: _____ First: _____ Middle: _____

STATEMENT OF APPLICANT:

- I fully understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of appointment to, or summary dismissal from, the Fellowship Program.

- All information submitted by me in this application is true to the best of my knowledge and belief.

- I authorize the University and their representatives to consult with other hospitals and institutions and their representatives and others, in regard to this application.

- I release from liability the University, their representatives and agents for their actions or omissions performed in good faith and without malice in evaluating the application as well as those who provide information to the University in good faith and without malice, and I consent to the release of such information, including otherwise privileged or confidential information.

- I consent to the release of information to other hospitals and institutions and person with a legitimate interest and agree to hold the University , their representatives and agents from of liability for this actions performed in good faith as a part of the quality assurance program, the credentialing process, peer review and medical evaluation activities.

- I understand that the information required herein is continuing in nature and agree to provide any changes in the information proved, i.e. address, name, certification and dates, licensure, etc. I agree to furnish upon request an update of any information provided in this application.

A copy of the Statement of Applicant may be used as an original.

Date: _____ Signature: _____

Printed Name: _____