** Consultation Liaison Psychiatry Fellowship Application**

Date of Application**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Beginning Year: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

Current Mailing Address:

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

Telephone: Home ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Work ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Preferred Method of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visa Status (if international medical graduate): \_\_\_\_\_ ECFMG number /date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current PG Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Passed USMLE Step I: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_USMLE Step II: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date) (Score) (Date) (Scores)

USMLE Step III: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date) (Scores)

Passed

COMLEX Level 1: \_\_\_\_\_\_\_\_\_\_\_\_ Level 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(for DO training) (Date) (Date) (Date)

Board Certified? If "yes" enter name of Board and Year Certified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LICENSURE: State: \_\_\_­\_\_ Number: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Type: \_\_\_\_\_\_\_\_ Expiration: \_\_\_\_\_\_

**Recommendation Letters**

A minimum of three and no more than four letters of recommendation from professionals with whom you have worked and/or studied. Please list the names of whom your letters will be from below.

* 1. One letter must be from your current or past program director
	2. Medical School Program Evaluation/Dean’s Letter *(required for PGY-2 applicants only)*
	3. Two to three additional letters of your own choosing
	4. Letters must be signed originals
	5. All letters must address your clinical performance.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send the letters to:

Michelle B. Riba, M.D.

Director, Consultation Liaison Psychiatry Program

Department of Psychiatry

4250 Plymouth Road

Ann Arbor, MI 48109-2700

For questions, please contact:

Chelsea Denniss, MHA - Program Coordinator

Tel: (734) 232-0487

Fax: (734) 232-0422

Email: cmatzing@med.umich.edu

**Educational Data**

**Undergraduate Education**: Please provide full name and mailing address for all schools listed.

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

Institution Address

Attended From: \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ Degree awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Institution Address

Attended From: \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ Degree awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Graduate Education** (Medical and Masters or Doctoral Program)

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

Institution Address

Attended From: \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ Degree awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Institution Address

Attended From: \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ Degree awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Postgraduate Medical Education:**

**Internship:** (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACGME Accredited Yes € No €

Address

**Residencies:** (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACGME Accredited Yes € No €

Address

**Fellowships:** (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACGME Accredited Yes € No €

Address

**Other Professional training:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACGME Accredited Yes € No €

**Work Experience**

**Relevant Work Experience:**

**Research Experience and/or Interests:**

**Publications/Presentations at scientific meetings** Yes € No € (Please list)

**Honors / Awards:**

**Professional Memberships:**

**Outside Interests / Achievements:**

**Personal Statement**

Please describe your interest in the field and plans for future professional work. (1,000-word limit*).*

*Note: lapses of more than 1 month of training should be explained in your personal statement.*

**Attestation Statement**

1. Malpractice

If there have been settlements, malpractice claims, and/or lawsuits pending or closed during the previous 10 years, please describe on a separate page.

1. Miscellaneous
	1. Has your professional license in any state ever been revoked, suspended, canceled or restricted ⁪ Yes ⁪ No
	2. Have you ever been denied a professional license in any state? ⁪ Yes ⁪ No
	3. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge? ⁪ Yes ⁪ No
	4. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? ⁪ Yes ⁪ No
	5. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason? ⁪ Yes ⁪ No
	6. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? ⁪ Yes ⁪ No
	7. Have you ever been convicted of a felony in a criminal action? ⁪ Yes ⁪ No

*Important: If you answered “Yes” to any of the above questions, please attach a written explanation.*

Applicant’s affidavit:

I certify that all the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment.

E-signature of Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_