Boston Medical Center
Boston University School of Medicine
Academic Primary Care Fellowship Program

Dear Applicant,

Thank you for inquiring about our primary care fellowship program. Enclosed is a brief description of the program and application materials.

There are three parts to the application. The first is our standard application and CV, please complete it as instructed. The second is a personal statement describing the reason for your interest in this program including your career goals and how these can be facilitated by acceptance into the Fellowship Program. You may want to explain how past experiences influenced your decision to apply and mention special areas of interest. Please limit this to one page. Third, we request letters of recommendation and the completion of a confidential reference form by three individuals. For physician, one of these letters should be from your residency program director, for all other applicants one letter should be from your thesis advisor or someone you have worked closely with. All pieces of the application should be emailed to Linda.Neville@bmc.org

Applications are considered on a rolling basis. Once we have all three parts, your application will be reviewed, and we will contact you to schedule an interview.

Sincerely,

Caroline Kistin, MD, MSc
Director, General Academic Pediatrics Fellowship

Michael Paasche-Orlow, MD, MA, MPH
Director, General Internal Medicine Fellowship

Alexander Walley, MD, MSc
Director, Addiction Medicine Fellowship

Stephen A. Wilson, MD, MPH, FAAFP
Chair, Department of Family Medicine

General Instructions for Completion Of this Application

Each section must be complete and legible or your application will be deemed incomplete.

If a section does not apply to you, write in N"/A." Do not leave any block blank.

All chronology must be accounted for from the completion of your medical/professional degree, to the present.

If additional space is needed, attach additional pages (make reference to the question being answered) or, copy the blank application page as often as necessary to provide complete information.

Keep these additional pages in sequence with corresponding application pages.

Your CV should include memberships, awards and honors and publications.

Primary Care Academic Fellowship Program
Addiction Medicine Fellowship
Preventive Medicine Residency
Boston Medical Center

The fellowships are based in the Departments of General Internal Medicine, Family Medicine and General Pediatrics at Boston University School of Medicine and Boston Medical Center. BMC has over a 100-year history of caring for the poor and underserved. And much of our research and many of our programs focus on improving the lives of these populations. The clinical service has approximately 2,000 admissions and 75,000 ambulatory visits each year.

T32 Training Awards from the Health Resources and Services Administration & AHRQ, along with institutional funding, support the fellowship. The training program is two to three years in length; over half of all trainees stay in the program for three years. Eighty percent of our graduates go on to pursue careers in academia.

The primary objective of the fellowship is to develop research competency, so that trainees can become successful independently supported physician-scientists. The specific objectives are to:

1. Gain experience and knowledge in research design;
2. Master statistical methods used in research and the interpretation of the medical literature;
3. Understand the importance of appropriate statistical consultation;
4. Become familiar with the problems and challenges of performing research;
5. Conduct, analyze, present and publish the results of independent research projects in areas reflecting the objectives of Healthy People 2030;
6. Complete at least one research project, culminating in a presentation and publication;
7. Prepare a grant application prior to completion of the training program; and
8. Develop skills in other areas that contribute to academic success, such as teaching and communication.

The development of research competency is accomplished through intensive mentoring and by course work at Boston University School of Public Health leading to a Master of Science in Population Health in either Epidemiology or Translation and Implementation Science. Research seminars, participation in the Developing Your Research Career program at BUSM, completion of both directed and independently developed research projects, teaching seminars, regular journal clubs and attendance at regional and national research/scientific meetings are also part of the curriculum.

Eligible candidates for fellowship training are either:

-Physicians who have completed residency training in family medicine, internal medicine, pediatrics or medicine/pediatrics, who intend to build academic careers in primary care and to focus on medically underserved populations and other high risk groups, and who are US citizens or permanent resident aliens.

- Non-Physician Applicants (including DNP & PhD nurses): Pre- and Post-doctoral applicants must be US citizens or permanent residents. Pre-doctoral fellowship candidates must have completed a Master's degree in a relevant field, including: MS, MPH, MBA, MSW or equivalent. Postdoctoral fellowship candidates must have completed a PhD or equivalent.

FOR ADDITIONAL INFORMATION

Contact Dr. Michael Paasche-Orlow at Michael.Paasche-Orlow@bmc.org

Applicant's Name: ___________________________________

Instructions: Complete all sections (please 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 nor make reference to an attached CV.

1. Name: Last	First	Middle
2. Preferred Name:	Pronouns:	
3. Current / Local Address (include street, city, state, and zip):		
4. Telephone Numbers: Cell:	Home:	
5. Permanent Address (include street, city, state, and zip):		

6. Emergency Contact:

Name	Relationship	Mailing Address	Telephone Number
____________________	________________	______________________________	________________

7. E-mail Address:

Please indicate which program(s) you are interested in:

- ☐ Addiction Medicine Fellowship (Research Year)
- ☐ Family Medicine Fellowship
- ☐ General Internal Medicine Fellowship
- ☐ General Pediatric Medicine Fellowship
- ☐ Preventive Medicine Residency (ACGME Accredited)
- ☐ Women's Health Fellowship

Please indicate which concentration(s) you are interested in:

- ☐Addiction Medicine
- ☐Health Disparities
- ☐Medical Education
- ☐Women's Health

Applicant's Name: ___________________________________

8. Citizenship: I

Permanent Resident: Yes No

Visa Type: ☐ H1-B ☐ J1 ☐ Other:_____________

Entrance Date into U.S.______________________ Length of Stay Valid to __________________

9. Current Position:

10: Academic Interest:

11. College(s) Attended (undergraduate education):

Name(s) of School : ____

Mailing Address : ____

Month/Years Attended : ______________________________ Degree(s) Conferred: __________________

(Use continuation sheet, if necessary)

12. Professional Education (medical school) or other doctoral program:

Name(s) of School : ____

Mailing Address : ____

Month/Years Attended : ______________________________ Degree(s) Conferred: __________________

(Use continuation sheet, if necessary)

13. For International Medical School Graduates: ECFMG No. _________________ Valid to ________________
(Provide a copy of your certificate)

14. Internship, Residencies, Other Postdoctoral Training & Fellowship Programs:

* Name(s) of Program : ____
Mailing Address : ____
Dates Attended (Month/Years): _________________________ Service or Subject: ____________________

* Name(s) of Program : ____
Mailing Address : ____
Dates Attended (Month/Years): _________________________ Service or Subject: ____________________

* Name(s) of Program : ____
Mailing Address : ____
Dates Attended (Month/Years): _________________________ Service or Subject: ____________________

(Use continuation sheet, if necessary)

Applicant's Name: ___________________________________

15. USMLE Scores: Step I _________________Step II _________________Step III ______________
Clinical Skills Assessment ______________________
Pass ☐ Fail ☐

16. Hospital Appointments (other than what is included in your training program): List chronologically, appointments to other hospital staffs showing name of hospital, mailing address of hospital, type of appointment (e.g., Active, Moonlighter, OPD, etc.)

* Name of Hospital: ____
Current Mailing Address: ____
Dates of Appointment : ______________________ Type of Appointment: ______________

* Name of Hospital: ____
Current Mailing Address: ____
Dates of Appointment : ______________________ Type of Appointment: ______________

(Use continuation sheet, if necessary)

17. Other Positions (other than what is included in your training program): List chronologically, any positions including the name and mailing address of the institution.

* Name of Institution: ____
Current Mailing Address: ____
Dates of Appointment : ______________________ Type of Appointment: ______________

* Name of Institution: ____
Current Mailing Address: ____
Dates of Appointment : ______________________ Type of Appointment: ______________

(Use continuation sheet, if necessary)

18. 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.**

(Use continuation sheet, if necessary)

19. Licensure: List any health occupation license or registration ever held, showing state(s), country(ies), number(s), date(s), and status.

Applicant's Name: ________________________________

20. Languages Spoken and fluency:

21. References: Names and addresses of three people who have worked extensively with you or have been responsible for professional observation of you. Do not list: relatives by blood or marriage; the Chief of Service to which you are applying (for physicians); persons in current training program with you; nor persons who cannot attest to your current level of clinical competency, technical skill, and medical knowledge for physicians and research competency and knowledge for PhDs.

	Name	Mailing Address and e-mail	Day-time Telephone
1.	____________	____________	____________
		____________	Fax # ____________
		____________	
		____________	
2.	____________	____________	____________
		____________	Fax # ____________
		____________	
		____________	
3.	____________	____________	____________
		____________	Fax # ____________
		____________	
		____________	

Applicant's Name: ___________________________________

Continuation Page: Use this page to document additional information. Copy as necessary.

Applicant's Name: ___________________________________

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 Hospital Medical Staff and/or Boston Medical Center.

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

-- I authorize the Hospital and/or 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 Hospital and/or 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 Hospital and/or 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 persons with a legitimate interest and agree to hold the Hospital and/or the University, their representatives and agents free of liability for their 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 I agree to provide any changes in the information provided; i.e., address, name, certification and dates, licensure, etc. I agree to furnish, upon request, an update on any information provided in this application.

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

Date ___________________________________ Signature ______________________________________

Printed Name ___________________________________

Boston Medical Center does not discriminate on the basis of race, color, gender, sex, religion, age, national or ethnic origin, sexual orientation, handicap, veteran status, or any other occupationally irrelevant criteria.

Name: ___________________________ please print Date Completed: ________________________________

Supplemental Biographical Information

The information requested is for grant reporting purposes only and will not be used during consideration of the application.

1. Date of Birth	2. Place of Birth	

3. Which of the following most accurately describe(s) you? Choose as many as you like

Female
Male
Non-binary
Transgender
Intersex
Let me type..
I prefer not to say

4. Ethnicity/Race (Self Identification)

A. Ethnicity:
Of Hispanic of Latino Origin (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin regardless of race)
Not of Hispanic or Latinx origin

B. Race:
Black or African American: A person having origins in any of the original groups of Africa

Asian or Asian American: Includes persons having origins in any of the original peoples of the Far East, Southeast Asian the Indian sub-continent (e.g. Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).

American Indian or Alaskan native: Includes persons having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

White: Includes persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

5. Disadvantaged Background. An individual from a disadvantaged background is defined as someone who**:**

Comes from an environment that has inhibited the individual from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school, or from a program providing education or training in an allied health profession. **OR** Comes from a family with an annual income below a level based on low-income thresholds according to family size published by the U.S. Bureau of the Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary of Health and Human Services for use in health professions and nursing programs.

YES □ NO □

Applicant, you need three of these forms for your three references. Please see instructions on the form.

CONFIDENTIAL REFERENCE REPORT

TO THE APPLICANT: Please complete before presenting to the reference.

Applicant's Name ______________________________

Applicant's Address ______________________________

Applicant's Telephone Number ______________________________

TO THE REFERENCE:

The candidate whose name appears above considers you able to assess his/her qualifications as a fellow candidate for the Boston Medical Center Academic Primary Care Fellowship Program. The program provides research and teaching opportunities in family medicine, general internal medicine, pediatrics and general surgery to physicians who have completed their residencies and aspire to faculty positions. Formal training in teaching methodologies, epidemiology, statistics, and health care research will be offered. Each fellow must design, implement and analyze a research project and will be directly involved in health care delivery and medical and graduate medical education.

INSTRUCTIONS:

(1.) Please complete the chart on the right. Rate the applicant by writing the number which most nearly represents your opinion of the applicant in comparison with a representative group of individuals you have known who have had approximately the same training and experience.

(2.) In an accompanying letter, please elaborate on the applicant's performance on the basis of which you arrived at your assessment, citing, if possible, specific illustrations. In addition, indicate the candidate's points of greatest strength and weakness and comment on his/her personal and professional qualifications for a career in academic medicine.

This Form Will Not Be Reviewed Without the Accompanying Letter

(3) DO NOT RETURN THE COMPLETED FORM TO THE APPLICANT. PLEASE MAIL DIRECTLY TO:

Linda Neville
801 Massachusetts Ave, Rm 2070
Boston, MA 02118
linda.neville@bmc.org

	Unable To Judge 0	Poor Lowest 25% 1	Fair Middle 26%-75% 2	Excellent Top 76%-90% 3	Outstanding Top 91-100% 4
Initiative					
Ability to meet deadlines					
Clinical/Research ability					
Interpersonal facility with peers					
Interpersonal facility with patients					
Potential skill at research					
Clinical or Research judgment/ critical sense					
Academic performance					
Leadership capacity					
Ability to function in a stressful environment					
Ability to communicate (Written)					
Ability to communicate (Spoken)					
Teaching ability					
Overall evaluation					

Signature of person providing reference ______________

Printed name of person providing reference ______________

Date ______________

Title of person providing reference ______________

Institution ______________

Telephone Number ______________