Joan and Sanford I. Weill Graduate School of
Medical Sciences of Cornell University
Fellowship Program in Complementary and Integrative Medicine

APPLICATION FOR ADMISSION

525 East 68th Street, Box #46

New York, NY 10021, USA

Tel: (212) 746-1608 Fax: (212) 746-8965

Instructions for Application for Admission

1. Applicants for admission must be graduates of an approved college or university and must show evidence of fitness for advanced work as indicated by their scholastic records, training, and experience.

   All documents, including translations of documents, must be official, i.e., must bear original signatures and seals. Do not fax application form or supporting documents; only correspondence can be faxed.
   No final action can be taken on applications until the following supporting documents have been reviewed:

   a. Complete official transcripts of all previous college and university work, including summer schools. A *final* transcript must be supplied after the completion of current degree requirements. A photocopy of your Medical School Diploma.

   b. At least two letters of recommendation from professors or other professionals with knowledge of the applicant's abilities in the areas of academic aptitude and achievement and/or in carrying out professional work and responsibilities.

   c. *Official* GRE score reports (Verbal, Quantitative, Analytical and Advanced); *Official* MCAT score reports (Verbal, Quantitative, Analytical and Advanced); *Official* TOEFL score report if English is not native language. These reports must be sent *directly* to the Graduate School of Medical Sciences by the Educational Testing Service, Princeton, NJ. **(If the applicant has an M.D. degree – the following requirement is waived.)**

   d. A personal statement: Please provide a concise description of your research experience and research interests. (Your essay should not exceed one typed page, single-spaced, and using a font not smaller than 12 points.)

   e. An updated curriculum vitae.

2. An application fee of $50, payable by check or money order to Graduate School of Medical Sciences of Cornell University, must accompany this application form.

3. Mail this application and have all supporting materials forwarded to the above address.

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APPLICATION FOR ADMISSION

Note: Program begins July 1st

Proposed year of admission: ____________

I. PERSONAL DATA

1. Name____
   (last) (first) (middle)

2. Home Address: ____

   ____Telephone: (___)__________________

3. Present Address (if different):

   ____

   ____Telephone: (___)_____________

3A. E-mail address:____

4. Place of birth: ______________________________ 4A. Date of Birth __________

5. Citizenship: ______________________ 6. Social Security Number ____________

7. Number of dependents: ____

8. Name of spouse/significant other:

   ____
   (last) (first) (middle)

9. In case of emergency, notify (name, contact information):

   ____

   ____

10. Are you a United States citizen? Yes ___ No ___

    If not, are you a U.S. national (do you have a green card?) Yes ___ No ___
    If yes, please provide documentation.

11. A graduate of a foreign medical school (except Canada): You are required to be certified by the Educational Council for Foreign Medical Graduates.

If you are certified, indicate below:

[ ] Standard Certificate: Number_________________Photocopy must be enclosed.

[ ] Interim certificate: Number___________________Photocopy must be enclosed.

Date of passing ECFM exam____

II. RESEARCH AND CAREER PLANS

1. Do you plan to take a subspecialty fellowship in the future? Yes [ ] No [ ]
please specify: ____

____

2. Do you plan to earn any further degrees in the future? Yes [ ] No [ ]

please specify: ____

3. Describe your research interests:

4. Describe the position you think you would want after completing the Fellowship Program:

5. Describe your long-term goals:

6. The usual period of time for a Fellow to be associated with the Program is two years. If you will require more or less time, please explain why.

7. If you wish, provide any additional information that may be helpful to the Selection Committee.

8. If you have published, please list your publications (books, monographs, and/or articles). Please indicate the single publication which represented your best work. You may attach a list of your publications if one is already typed. Abstracts and publications should be separated.

THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS REQUIRES ALL REMAINING QUESTIONS IN SECTIONS III and IV

III STATE OF HEALTH.

Present state of health: ______________________________

Date of last physical examination: ______________________________

Significant findings: ______________________________

____

Name and address of physician and/or institution where physical examination

performed:____

____

Dates and causes of all hospitalizations for prior five years:____________________

____

Physical disabilities or limitations: ______________________________________

____

IV. EDUCATION, LICENSURE AND EXPERIENCE

1. High School: ____
(name and location) (date of graduation)

2. College: ____
(name and location) (major field) (degree and date)

3. Postgraduate:____
(name and location) (major field) (degree and date)

4. Medical School: :____
(name and location) (major field) (degree and date)

Honors?____

____

5. Internships: A. ____
(most recent first) (hospital) (location)

____
(date) (type)

B. ____
(hospital) (location)

____
(date) (type)

5. Residencies: A. ____
(most recent first) (hospital) (location)

____
(date) (type)

B. ____
(hospital) (location)

____
(date) (type)

C. ____
(hospital) (location)

____
(date) (type)

7. Fellowships (most recent first and give specific dates):

____

____

____

____

Board and/or Subspecialty Board Certified: ________________________

8. Have your privileges at any hospital or other facility ever been denied, limited, suspended, revoked or not renewed? And/or have you ever been denied membership or a renewal therein or been subjected to disciplinary proceedings in any hospital or medical organizations?

Yes [ ] No [ ] If yes, give full details on separate sheet.

9. Licensures:

____
(jurisdiction) (date issued) (license #)

____
(jurisdiction) (date issued) (license #)

____
(jurisdiction) (date issued) (license #)

Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?

Yes [ ] No [ ] If yes, give full details on separate sheet.

Are any of your licenses limited or temporary? Yes [ ] No [ ] If so, give details:____

____

____

10. National and State Board examinations:

____
(date) (state) (number) (result)

____
(date) (state) (number) (result)

____
(date) (state) (number) (result)

V. REFERENCES:

Please arrange to have three letters of reference submitted promptly. One <u>must</u> be from the Director of your current or most recent clinical training program. List the three referring faculty members from whom we can expect to hear:

____
(name) (address) (title)

____
(name) (address) (title)

____
(name) (address) (title)

______________________________ ______________________________
(signature) (date)