**APPLICATION INSTRUCTIONS**

Please save a completed copy of this application and return it as an email attachment, along with your CV, to GIMfellowship@bidmc.harvard.edu.

Letters of recommendation should be addressed to:

Mara Schonberg M.D., M.P.H. and Travis Baggett, M.D., M.P.H.

Program Directors

Harvard Medical School Fellowship in General Medicine and Primary Care

These letters of recommendations can be submitted as an email attachment to GIMfellowship@bidmc.harvard.edu.

**Applications are due by July 8th.**

If you have any questions about the application process, please contact Sopheap Lim at slim5@bidmc.harvard.edu or 617-754-1426.

The program is particularly interested in receiving applications from individuals from underrepresented minority groups. Many research projects conducted by the faculty focus on the care of minority and other underserved populations. Harvard Medical School and each of the participating fellowship sites are equal opportunity employers.

**HARVARD MEDICAL SCHOOL FELLOWSHIP IN GENERAL MEDICINE AND PRIMARY CARE**

**For Fellowships Beginning July 1, 2025**

**Please review instructions on the previous page before completing this application.**

1. **PERSONAL DATA**
	1. **Full Name** (First, Middle Initial, Last Name): Click or tap here to enter text.
	2. **Home Address**: Click or tap here to enter text.
	3. **Present Address** (if different from above): Click or tap here to enter text.
	4. **Phone Number**: Click or tap here to enter text.
	5. **Email Address**: Click or tap here to enter text.
	6. **Name of Spouse**: Click or tap here to enter text.
	7. **In case of emergency, notify**: Click or tap here to enter text.
	8. **Date of Birth**: Click or tap here to enter text.
	9. **Last 4 Digits of SSN**: Click or tap here to enter text.
	10. **Are you a citizen of the United States, a non-citizen U.S. National of a Permanent Resident** (I-551 or I-151)?

**Yes** [ ]  **No** [ ]

* 1. **If you are 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, please indicate below**:

Standard Certificate Number: Click or tap here to enter text.

Date of passing ECFMG exam: Click or tap here to enter text.

A copy of the certificate must be sent as a PDF file with this application to GIMfellowship@bidmc.harvard.edu.

* 1. **Do you have any disabilities or limitations that would prevent you from performing the responsibilities of this fellowship?**

**Yes** [ ]  **No** [ ]

1. **EDUCATION, LICENSURE, AND EXPERIENCE**

**Please complete the following sections (as applicable) about your educational background.**

1. **High School:** Name and Location**:** Click or tap here to enter text.

Degree and Date**:** Click or tap here to enter text.

1. **College:** Name and Location: Click or tap here to enter text.

Degree and Date**:** Click or tap here to enter text.

1. **Graduate: (i.e. non-clinical** Name and Location: Click or tap here to enter text.

**Masters or Doctoral degrees)** Degree and Date: Click or tap here to enter text.

Honors: Click or tap here to enter text.

1. **Nursing School:** Name and Location: Click or tap here to enter text.

Degree and Date: Click or tap here to enter text.

Honors: Click or tap here to enter text.

1. **Medical School:** Name and Location: Click or tap here to enter text.

Degree and Date: Click or tap here to enter text.

Honors: Click or tap here to enter text.

1. **Residency and Internship Training** (most recent first): Hospital: Click or tap here to enter text.

Location**:** Click or tap here to enter text.

Date**:** Click or tap here to enter text.

Type**:** Click or tap here to enter text.

Hospital: Click or tap here to enter text.

Location**:** Click or tap here to enter text.

Date**:** Click or tap here to enter text.

Type**:** Click or tap here to enter text.

Hospital: Click or tap here to enter text.

Location**:** Click or tap here to enter text.

Date**:** Click or tap here to enter text.

Type**:** Click or tap here to enter text.

Hospital: Click or tap here to enter text.

Location**:** Click or tap here to enter text.

Date**:** Click or tap here to enter text.

Type**:** Click or tap here to enter text.

 **Fellowships** (most recent first and give specific dates): Click or tap here to enter text.

Subspecialty Board Certified**:** Click or tap here to enter text.

1. **If you had had a previous fellowship, was it funded by a National Research Service Award (NRSA)?** (If you are unsure, please contact the program).

**Yes** [ ]  **No** [ ]  **If yes, years funded:** Click or tap here to enter text.

1. **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 organization?**

 **Yes** [ ]  **No** [ ] If yes, please provide full details on a separate sheet.

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

**Yes** [ ]  **No** [ ] If yes, please provide full details on a separate sheet.

1. **Have you ever voluntarily relinquished your license?**

**Yes** [ ]  **No** [ ]  If yes, please provide full details on a separate sheet.

1. **National and State Board Examinations** (USMLE or equivalent):

Date: Click or tap here to enter text.

State: Click or tap here to enter text.

Number: Click or tap here to enter text.

Pass [ ]  Fail [ ]

Date: Click or tap here to enter text.

State: Click or tap here to enter text.

Number: Click or tap here to enter text.

Pass [ ]  Fail [ ]

1. **Please tell us how you heard about the fellowship program** (check all that applies):

[ ] SGIM Website

[ ] Advertisement in Journal (please specify): Click or tap here to enter text.

[ ] Advisor/Mentor (please specify): Click or tap here to enter text.

[ ] Friend/Associate (please specify): Click or tap here to enter text.

[ ] Other (please specify): Click or tap here to enter text.

1. **RESEARCH AND CAREER PLANS**
2. **Do you plan to pursue a subspecialty fellowship in the future?**

**Yes** [ ]  **No** [ ]  **If yes, please specify:** Click or tap here to enter text.

1. **Do you plan to earn any further degrees in the future?**

**Yes** [ ]  **No** [ ]  **If yes, please specify:** Click or tap here to enter text.

1. **Why are you interested in the General Medicine Fellowship Program?** *(Please limit responses to 300 words or less)*:

Click or tap here to enter text.

1. **Describe your research interest** *(Please limit responses to 500 words or less)*:

Click or tap here to enter text.

1. **Describe the position you think you would want after completing the Fellowship Program** *(Please limit responses to 500 words or less)*:

Click or tap here to enter text.

1. **Describe your long-term goals** *(Please limit responses to 500 words or less)*:

Click or tap here to enter text.

1. **The usual time period for a fellow to be associated with the program is two years. If you will require more time, please explain why.**

Click or tap here to enter text.

1. **Please provide a personal statement (attach separately) with any additional information that may be helpful to the Selection Committee.**

1. **If you have been published, please list your publications** (articles, books, and or monographs). **Please indicate the single publication which represents your best work.** (Abstracts and publications should be listed separately).

Click or tap here to enter text.

1. **Do you currently prefer a participating institution at which you would do your research and clinical work?**

**Yes** [ ]   **No** [ ]

**If yes, please rank the following sites (1=Highest, 6=Lowest).** Your indication of a current preference is not binding – we will ask you to again list your preferences prior to the final selection process.

Select a Value **Beth Israel Deaconess Medical Center**

Select a Value **Brigham & Women’s Hospital, Division of General Medicine**

Select a Value **Brigham & Women’s Hospital, Division of Pharmacoepidemiology**

Select a Value **Cambridge Health Alliance**

Select a Value **Dept of Population Medicine** (HMS/Harvard Pilgrim Health Care)

Select a Value **Massachusetts General Hospital**

1. **REFERENCES**

Please arrange to have three letters of references submitted. One must be from the Director of your current or most recent clinical training program. List the three individuals from whom we can expect to receive letters of recommendations on your behalf:

 Name: Click or tap here to enter text.

 Address: Click or tap here to enter text.

 Title: Click or tap here to enter text.

 Preferred Method of Contact: Click or tap here to enter text.

 Name: Click or tap here to enter text.

 Address: Click or tap here to enter text.

 Title: Click or tap here to enter text.

 Preferred Method of Contact: Click or tap here to enter text.

 Name: Click or tap here to enter text.

 Address: Click or tap here to enter text.

 Title: Click or tap here to enter text.

Preferred Method of Contact: Click or tap here to enter text.

Fellows will start July 1st of each calendar year. I certify that to the best of my knowledge and belief, all of my statements are true, correct, complete and made in good faith.

**Candidate Name**: Click or tap here to enter text. **Date**: Click or tap to enter a date.

(*Serves as signature*)

**HARVARD MEDICAL SCHOOL FELLOWSHIP IN GENERAL MEDICINE AND PRIMARY CARE**

**Self-Identification Form**

Harvard University is subject to certain governmental recordkeeping and reporting requirement for the administration of civil rights laws and regulations. In order to comply with these laws, Harvard invites its trainees to voluntarily self-identify their ethnicity, race, and sexual orientation and gender identity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

**Do you consider yourself to be Hispanic/Latino?**

[ ]  Yes (A person of Cuban, Chicano, Mexican, Mexican American, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

[ ]  No

**In addition, please select one or more of the following racial categories to describe yourself, if applicable**:

[ ]  American Indian or Alaskan Native: A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliation or community attachment.

[ ]  Asian, not underrepresented: A person having origins in any of the any of the Asian subpopulations not considered underrepresented in the health professions includes Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, Vietnamese, Malaysian

[ ]  Asian, underrepresented: A person having origins in any of the Asian subpopulations considered underrepresented in the health professions include any Asian **OTHER THAN** Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, Vietnamese, Malaysian (*i.e., Cambodian, or Laotian*)

[ ]  Black or African-American: A person having origins in any of the black racial groups of Africa

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

[ ]  White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

[ ]  Another race or ethnicity not listed above

**Do you identify as a sexual or gender minority (i.e. lesbian, gay, bisexual or transgender)?**

[ ]  Yes

[ ]  No

**Self-Identification for Veterans Status**

As an affirmative action employer, Harvard is subject to certain federal recordkeeping and reporting requirements. In order to assist the University in complying with these requirements, we offer you the opportunity to complete this self-identification form. Submission of this information is voluntary and disclosing or declining to provide it will not subject you to adverse treatment. The information will be used in a manner consistent with federal and state laws.

**Please indicate if you are a:**

[ ]  Disabled Veteran: Veteran of the U.S. military who is entitled to compensation (or who but for receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veteran Affairs, or a person who was discharged or released from active duty because of service-connected disability

[ ]  Recently Separated Veteran: Any veteran during the three-year period beginning on the date of such veteran’s discharge or release from active duty in the U.S. military

[ ]  Armed Forces Service Medal Veteran: Veteran who, while serving on active duty in the U.S. military, participated in a U.S. military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985

[ ]  Other Protected Veteran: Veteran who served on active duty in the U.S. military during a war or in a campaign or expedition for which a campaign badge has been authorized under laws administered by the Department of Defense

[ ]  Not a Veteran: None of the above apply

[ ]  I choose not to self-identify at this time

**Self-Identification for Persons with Disabilities**

In accordance with Sections 503 and 504 of the Rehabilitation Act of 1973, the provision of this information is on a voluntary basis and will be maintained in a separate location for affirmative action program use and will not be included in the personnel file of any employee for employment.

**DEFINITION: DISABILITY STATUS**

The following are examples of some, but not all, disabilities which may be included: AIDS, asthma, arthritis, color or visual blindness, cancer, cerebral palsy, deafness or hearing impairment, diabetes, epilepsy, HIV, heart disease, hypertension, learning disabilities, mental or emotional illnesses, multiple sclerosis, muscular dystrophy, orthopedic, speech or visual impairments, or any other physical or mental impairment which substantially limits one or more of your major life activities. Please indicate if you are:

[ ]  Disabled [ ]  Not disabled

**Self-Identification Form for Persons from Disadvantaged Backgrounds**

We are required to report the number of individuals applying to, admitted to, and graduated from our program who meet federal definitions for coming from “disadvantaged backgrounds” or “medically underserved communities.” The provision of this information is voluntary and will not be included in the personnel file of any employee for employment.

**The definition of “Disadvantaged”** is that which is currently in use for health professions programs (42 CFR 57.1804 (c)) and includes both economic and educational factors that are barriers to an individual’s participation in a health professions program. This means an individual who:

1. is 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
2. is 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, and adjusted annually for changes in the Consumer Price Index, and by the Secretary for use in health professions programs.

**“Medically Underserved community”** means an urban or rural population without adequate health care services. If you are unsure about whether your community qualifies, we can use the following geographic information to make that determination:

State: Click or tap here to enter text.

County: Click or tap here to enter text.

City / Town: Click or tap here to enter text.

**Please indicate if you believe you are from a**:

Disadvantaged Background: [ ]  Yes [ ]  No [ ]  Unsure

Medically Underserved Community:[ ]  Yes [ ]  No [ ]  Unsure

Rural Residential Background: [ ]  Yes [ ]  No [ ]  Unsure

Please use the following link for guidance about rural residential background <https://datawarehouse.hrsa.gov/tools/analyzers/geo/Rural.aspx>

**Food Restrictions**

Please state below if you have any food restrictions (Gluten Intolerant, Kosher, Vegetarian, etc.) so that we can accommodate your needs if you visit.

Click or tap here to enter text.