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

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

Applications Due Date:

We are still accepting applications on a rolling basis and will continue to review applications until all fellowship positions have been filled. Applicants are strongly encouraged to submit a completed application by September 3, 2026, to have a broad choice of site placement.

If you have any questions about the application process, please contact Melania Gilzene at GIMfellowship@bidmc.harvard.edu or 617-754-1409.

Important Notice about HPSH Acceptance

Please note that acceptance into the Harvard Medical School Research Fellowship Program does not guarantee admission to HSPH. Applicants to this fellowship may be eligible to pursue a Master of Public Health (MPH) or Master of Science (MS) through the Harvard T.H. Chan School of Public Health (HSPH). To be considered for enrollment, a separate application must be submitted to HSPH by December 1, 2026.

If the December 1 HSPH application deadline is missed, approval for late submission may be granted by HPSH on a case-by-case basis. However, consideration is not guaranteed. Regardless, fellowship applicants should apply to HSPH's summer Program in Clinical Effectiveness (PCE). The application deadline for the PCE is typically in early February. Please refer to the fellowship website for the most up-to-date information. Credits earned through the PCE may be transferable toward a degree program upon subsequent acceptance to HSPH.

Beth Israel Lahey Health
Beth Israel Deaconess Medical

DEPARTMENT OF POPULATION MEDICINE
HARVARD MEDICAL SCHOOL
Harvard Pilgrim Health Care Institute

HARVARD MEDICAL SCHOOL RESEARCH FELLOWSHIP IN GENERAL MEDICINE

For Fellowships Beginning July 1, 2027

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

I. 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. **In case of emergency, notify**: Click or tap here to enter text.
7. **Date of Birth**: Click or tap here to enter text.
8. **Last 4 Digits of SSN**: Click or tap here to enter text.
9. **Are you a citizen of the United States, a non-citizen U.S. National OR a Permanent Resident** (I-551 or I-151)?

   Yes ☐ **No** ☐

10. **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.

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

Yes ☐ **No** ☐

II. EDUCATION, LICENSURE, AND EXPERIENCE

1. College:

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

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

2. Postgraduate (if any):

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

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

3. 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.

4. 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.

5. **If you have 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.

6. **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.

7. **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.

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

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

9. **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 ☐

10. 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.

III. RESEARCH AND CAREER PLANS

1. **Do you plan to pursue a subspecialty fellowship after the GIM Fellowship?**

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

2. **The usual time period for the fellowship is two years. If you require more time, please explain why.**

Click or tap here to enter text.

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

Click or tap here to enter text.

4. **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	**Brigham & Women's Hospital Medicine Fellowship**
Select a Value	**Cambridge Health Alliance**
Select a Value	**Dept of Population Medicine** (HMS/Harvard Pilgrim Health Care)
Select a Value	**Massachusetts General Hospital**

Please provide a personal statement no longer than 1000 words that address the following items:

- **Your research interests**
- **Why you are interested in the HMS General Medicine research fellowship**
- **Your goals for fellowship**
- **The position you hope to take after the fellowship**
- **Your long-term goals**
- **Any additional information you think would be helpful to the committee.**

IV. 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. (*Serves as signature*)

Date: Click or tap to enter a date.