



Forensic Psychiatry Fellowship Program
Division of Forensic Psychiatry
Department of Psychiatry
SUNY Upstate Medical University
750 E. Adams Street, Syracuse, NY 13210
PH: 315-464-3104 FX: 315-464-3141

Forensic Psychiatry Fellowship Program
Application Form

Training to begin July \_\_\_\_\_ Current PGY Level \_\_\_\_\_

Name: \_\_\_\_\_
Last First Middle

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Telephone Number (day): \_\_\_\_\_ (night): \_\_\_\_\_

If not a U.S. citizen, do you have the legal right to remain in the U.S.? [ ] Yes [ ] No

If you are a non-immigrant, please give you type of visa: \_\_\_\_\_

ECGME Certificate Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

USMLE: Part I [ ] Yes [ ] No Score: \_\_\_\_\_ Date: \_\_\_\_\_
Part II [ ] Yes [ ] No Score: \_\_\_\_\_ Date: \_\_\_\_\_
Part III [ ] Yes [ ] No Score: \_\_\_\_\_ Date: \_\_\_\_\_

Did you pass each part of the USMLE on the first try? [ ] Yes [ ] No

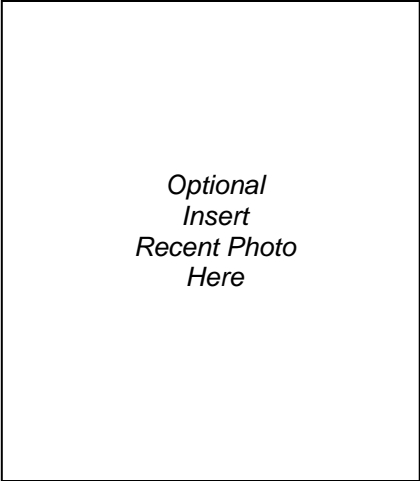
If not, which part(s)? [ ] I [ ] II [ ] III Number of times for each part? \_\_\_\_\_

Do you anticipate starting the fellowship later than July 1? [ ] Yes [ ] No

If yes, please explain: \_\_\_\_\_

Licensed to practice in the following states:

State: \_\_\_\_\_ License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
State: \_\_\_\_\_ License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_



**EDUCATION:**

High School:			
Address	Street	City/State/Zip Code	Country
	Date of Graduation:		Degree:
Undergraduate University			
Address:	Street	City/State/Zip Code	Country
	Date of Graduation:		Degree:
Post Graduate University			
Address:	Street	City/State/Zip Code	Country
	Date of Graduation:		Degree:
Medical School			
Address:	Street	City/State/Zip Code	Country
	Date of Graduation:		Degree:

**INTERNSHIP OR RESIDENCY TRAINING**

Institution (include full address)	Degree or Specialty	# Months Completed	Date Started	Date Completed (If in progress, indicate anticipated date of completion)

Please answer the following questions. If needed, use additional sheets of paper to complete your answers.

Has your education been interrupted for any reason other than for vacation?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been on academic probation or had a disciplinary action taken against you during medical school or residency?	Yes	No
If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

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Have you ever been placed on administrative leave during your training (including medical school, any post-graduate training)?

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If yes, please explain.

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Honors and Awards:

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Research Experience and Publications:

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Community Activities:

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If needed, use additional sheets of paper to complete your answers to the following questions:

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Why did you pick forensic psychiatry as a specialty?

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What are you looking for in a fellowship program?

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What has led you to be specifically interested in the fellowship at SUNY Upstate Medical University?

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**LETTERS OF REFERENCE:** One letter must be from your current (or most recent) Residency Program Director.

Residency Program Director Name and Title

Institution:

Full Address:

Phone Number:

Name and Title:

Institution:

Full Address:

Phone Number:

Name and Title:

Institution:

Full Address:

Phone Number:

Please arrange to have the letters of recommendation sent to:

James Knoll, M.D., Director  
Forensic Psychiatry Fellowship Program  
Department of Psychiatry  
SUNY Upstate Medical University  
750 E. Adams Street  
Syracuse, NY 13210

Applicant's Signature

Date

Applicant Name – Please type or print

NOTE: The signature and date of this statement must be original.

*I further authorize SUNY Upstate Medical University to contact my present/former Medical Education Director or Residency Program Director or any of the physicians with regard to my fellowship application. I further certify that the information contained in this application is complete and correct to the best of my knowledge. I understand that any false or missing information may disqualify me for this position.*

Signature of Applicant

Date

Note: The signature and date on this statement must be original.

Items to be included in your application packet:

Photo (optional)

CV

Personal Statement

Sample of writing (patient report or manuscript you may have put together for presentation)

Official undergraduate transcript(s)

Official medical school transcript

Copies of USMLE Step I, II, and III Score Reports

Copy of ECFMG Certificate

Copy of VISA (if needed)

Copy of medical school diploma

All items in the application packet should be sent to:

Linette Thorp

Program Coordinator

Forensic Psychiatry Fellowship Program

Department of Psychiatry

SUNY Upstate Medical University

750 E. Adams Street

Syracuse, NY 13210