

**Application for Observership Rotation**  
**Department of Psychiatry – 4B Inpatient Unit**  
**SUNY Upstate Medical University**

**Applicant Information**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First Middle name*

Other names you have used: \_\_\_\_\_

Name you would like to be called: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Nationality: \_\_\_\_\_ Gender: \_\_\_\_\_  
*MM/DD/YYYY M or F*

Date of availability to start the observership : \_\_\_\_\_ Visa Status: \_\_\_\_\_  
*MM/DD/YYYY*

Current Mailing address in the USA:  
\_\_\_\_\_  
*Street Address Apartment/Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

Phone: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

NOTE: Email will be the primary method of communication between the Upstate and the Applicant

Permanent Mailing Address: \_\_\_\_\_

**References- Include the name of a physician who has provided a reference/LOR**

Name and Current Mailing address  
\_\_\_\_\_  
*Name*  
\_\_\_\_\_  
*Address*  
\_\_\_\_\_  
*Address*

**Education- List the name of each institution attended. Provide the address of the institution and the dates of attendance. Use a sheet of paper if needed.**

1. Name and address: \_\_\_\_\_  
*Name Address*  
\_\_\_\_\_  
*Degree/certificate Dates attended*

2. Name and address: \_\_\_\_\_  
*Name Address*  
\_\_\_\_\_  
*Degree/certificate Dates attended*

3. Name and address: \_\_\_\_\_  
*Name* *Address*

\_\_\_\_\_ *Degree/certificate* *Dates attended*

4. Name and address: \_\_\_\_\_  
*Name* *Address*

\_\_\_\_\_ *Degree/certificate* *Dates attended*

**USMLE Scores**

1. Step I:	Date	Score	<b>1<sup>st</sup> Attempt</b>	<b>YES</b>	<b>NO</b>
				<input type="checkbox"/>	<input type="checkbox"/>
2. Step II:	Date	Score	<b>1<sup>st</sup> Attempt</b>	<b>YES</b>	<b>NO</b>
				<input type="checkbox"/>	<input type="checkbox"/>
3. Step II CS:	Date	Score	<b>1<sup>st</sup> Attempt</b>	<b>YES</b>	<b>NO</b>
				<input type="checkbox"/>	<input type="checkbox"/>
4. Step III:	Date	Score	<b>1<sup>st</sup> Attempt</b>	<b>YES</b>	<b>NO</b>
				<input type="checkbox"/>	<input type="checkbox"/>

**Postgraduate Experience: List the name and address of each program and/or experience attended regardless of whether the program was completed or credit was received**

1. Name and address: \_\_\_\_\_  
*Name* *Address*

\_\_\_\_\_ *Degree/certificate* *Dates attended*

2. Name and address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *Degree/certificate* *Dates attended*

3. Name and address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *Degree/certificate* *Dates attended*

4. Name and address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *Degree/certificate* *Dates attended*

**Questions**

Is any criminal action pending against you?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Are you required to register as a Sex Offender?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been denied a license to practice medicine in any country?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical board, other agency or hospital?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated for or had a recurrence of a diagnosed addictive disorder?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any other condition which in any way impairs or limits your ability to practice medicine safely?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>

**If yes to any, explain:**

### Complete application packet

- Completed application form
- Completed ranking of requested rotations
- Resume or Curriculum Vitae
- Proof of Up-To-Date immunizations
- Evidence of completion of medical education, including Medical School Transcript, if available
- USMLE Score Reports
- ECFMG certificate, if applicable
- Copy of Visa, if applicable
- Copy of passport, if applicable - information page, picture page, signature page, inside back cover page
- 1 passport photo
- \$300 cashier's check or money order for the non-refundable application fee made out to the SUNY Upstate Psychiatry Faculty Practice, Inc. **Personal Checks will not be accepted.**

**\*Any document that is written in a language other than English must be accompanied by an original, official translation.**

Please **mail** the completed packet to the following address.

**Upstate Medical University  
Department of Psychiatry  
Attn: 4B Observer Program  
750 E. Adams St.  
Syracuse, NY 13210**

### Rotation Preference

Rotation Dates	Rank Preference (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> etc)
December 9 – January 5, 2020	
January 6 – February 2, 2020	
February 3 – March 2, 2020	
March 3 – March 30, 2020	
March 31 – April 27, 2020	
April 28 – May 23, 2020	
May 24 – October 2020	<b>BLOCKED OUT</b>
October 13 – November 8, 2020	
November 9 – December 6, 2020	
December 7 – January 3, 2021	
January 4 – January 31, 2021	
February 1 – February 28, 2021	
March 1 – March 28, 2021	
March 29 – April 25, 2021	
April 26 – May 23, 2021	
May 23 – October 2021	<b>BLOCKED OUT</b>

### Disclaimer and Signature

***I certify that my answers are true and complete to the best of my knowledge. I have read the Observership Policy Overview and submit my application for the Observership Program at SUNY Upstate Medical University, Department of Medicine.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Applicant*

**OFFICE USE ONLY**

Applicant is approved for the following rotations:

Dates: \_\_\_\_\_ Rotation: \_\_\_\_\_ Payment Received: \_\_\_\_\_

Dates: \_\_\_\_\_ Rotation: \_\_\_\_\_ Payment Received: \_\_\_\_\_

Dates: \_\_\_\_\_ Rotation: \_\_\_\_\_ Payment Received: \_\_\_\_\_

Dates: \_\_\_\_\_ Rotation: \_\_\_\_\_ Payment Received: \_\_\_\_\_

**DEPARTMENT APPROVAL**

***This application is approved for the rotations described above. These rotations will be closely monitored to ensure that the applicant adheres to the Observership Policies of the Department of Medicine and the Institutional Policies of the Medical Staff Office of Upstate Medical University.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Department of Psychiatry 4B Director or Chair*