



GRADUATE MEDICATION EDUCATION RESIDENCY AND FELLOWSHIP APPLICATION 2024-2025

ERAS Code: 1511621091
Proposed Year of Admission:
July 1, 2024

Geriatric Medicine Fellowship Program

The Section of Geriatric Medicine at the University of Illinois at Chicago offers a one –year fellowship in Geriatric Medicine that is open to qualified applicants with previous training in internal or family medicine. The program provides comprehensive training in gerontology and geriatrics.

The clinical program offers supervised training in a variety of settings, including consultations to hospitalized patients. In the out-patient clinics, there is a geriatric assessment clinic for patients that need a comprehensive and longitudinal care. Similar services are also provided at our out-patient clinic at the Jesse Brown Veterans Administration Medical Center (JBVA), located across the street from campus.

Experience in post-acute care and nursing homes takes place at Pearl of Hillside, Warren Barr South Loop, Center home for the Hispanic, and Barton Assisted living facility. All of these facilities are located in Chicago, except for Pearl of Hillside, which is located in Hillside, the west suburbs of Chicago. Experience in the role of medical director and in the care of skilled and intermediate care nursing home residents is available.

Our Home Based Primary Care (HBPC) program, that is run by the JBVA, is an in-home service for frail, homebound veterans that exposes Fellows to the role of the medical director of a home health agency. The HBPC team also enjoys relationships with several community-based social service agencies, which allows fellows to understand the range of services these organizations provide.

There are block rotations in both hospice and palliative medicine that provides Fellows with the skills to care for individuals at the end of their life and teaches Fellows how to facilitate family meetings to address the goals of care a patient' of life care. At these sites there are clinical conferences, interdisciplinary conferences, and symposia. Fellows rotate through Physical Medicine and Rehabilitation, Transition of Care, Rheumatology, Wound Care, and Gero-Psychiatry, Neurology, and Endocrinology. Fellows may choose other elective rotations as well.

In addition to their clinical duties, Fellows have monthly journal clubs and weekly seminars in geriatric medicine. During the fellowship, there are opportunities to participate in research and quality improvement projects.



Application Requirements

In addition to this application you are required to submit the following information

- **A Current Curriculum Vitae that includes:**
 - Education
 - Academic honors, scholarships, and any other awards
 - Post Graduate Training
 - Fellowships Held
 - Board/Subspecialty Board Certifications
 - Research and Publications
- **Personal Statement** describing your interest in the geriatric medicine fellowship and your goals.
- **A copy of your USMLE transcripts**
- **A copy of your ECFMG if it applies to you**
- **Dean's Letter from your medical school**
- **3 letters of recommendation**
 - 1 must be from your current PD
- **Medical School Transcripts**
- **Medical School Diploma**



UIC Fellowship File Requirements

A complete UIC/GME resident application file consists of the documents listed below. **Please note:** *the UIC Office of Graduate Medical Education (GME) will not begin processing a resident file or issue a UIC Resident Agreement until documents #1-9 are on file in the GME office.*

Received	Required Application Document	Received Date
<input type="checkbox"/>	1. Residency Application	
<input type="checkbox"/>	2. Curriculum Vitae (CV)	
<input type="checkbox"/>	3. Personal Statement	
<input type="checkbox"/>	4. USMLE Score Sheets or Transcript (Steps 1, 2-CK <i>and</i> 2-CS; or equiv., e.g., COMLEX, NBDE)	
<input type="checkbox"/>	5. ECFMG Certificate (International Medical School Graduates Only)	
<input type="checkbox"/>	6. Medical / Dental School Diploma , <i>if in a foreign language please include official translations.</i>	
<input type="checkbox"/>	7. Dean's Letter (aka "Principal's Letter")	
<input type="checkbox"/>	8. Medical / Dental School Transcript , <i>if in a foreign language please include official translations.</i>	
<input type="checkbox"/>	9. 3 Letters of Recommendation/1 for internal candidates, within 12 months of application <input type="checkbox"/> 1 – Last Name: <input type="checkbox"/> 2 – Last Name: <input type="checkbox"/> 3 – Last Name:	1: 2: 3:
<input type="checkbox"/>	10. Letter of Good Standing* (only for applicants currently in a training program)	
<input type="checkbox"/>	11. Verification of Prior Training/Summative Evaluation* *(Only for applicants who are outside of UIC/UIH training programs that have completed resident and/or fellowship training domestically or internationally)	
* NOTE: The applicant cannot be involved in the process of requesting or submitting a Letter of Good Standing and/or Verification of Prior Training. This documentation must be sent directly from the current or prior training program to the UIC training program to which the applicant has been accepted.		

2024-2025 UIC Application for Fellowship/Residency

I hereby apply for clinical graduate training in _____, to begin

PERSONAL INFORMATION			
1. Name (Last) (First) (Middle)			2. Social Security Number
3. Citizenship <input type="checkbox"/> USA <input type="checkbox"/> Other:	4. Date of Birth	5. Place of Birth (City) (State) (Country)	
6. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		7. University ID Number (UIN)*	8. Nat'l Provider Identifier (NPI)**
9. Present Address (Street) (City) (State) (Zip) (Country)			
10. Telephone Number		11. Personal Email Address	
12. Permanent Address (Street) (City) (State) (Zip) (Country)			
VISA STATUS (if applicable)			
13. Current Visa Status <input type="checkbox"/> Permanent Resident Alien <input type="checkbox"/> J-1 <input type="checkbox"/> J-2 <input type="checkbox"/> H-1B <input type="checkbox"/> F-1 <input type="checkbox"/> O-1 <input type="checkbox"/> Asylee/Asylum <input type="checkbox"/> Temporary Protected Status (TPS) <input type="checkbox"/> Other (be specific):			
Yes or No: My <i>current</i> visa status includes an Employment Authorization Document (EAD)			<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Expected Visa Status <input type="checkbox"/> Permanent Resident Alien <input type="checkbox"/> J-1 <input type="checkbox"/> J-2 <input type="checkbox"/> H-1B <input type="checkbox"/> F-1(OPT) <input type="checkbox"/> O-1 <input type="checkbox"/> Asylee/Asylum <input type="checkbox"/> Temporary Protected Status (TPS) <input type="checkbox"/> Other (be specific):			
Yes or No: My <i>expected</i> visa status will require an Employment Authorization Document (EAD)			<input type="checkbox"/> Yes <input type="checkbox"/> No

* A UIN is an identification number specific to the University of Illinois system. A UIN is issued to all U of I students, employees and some temporary visitors.

** Information about applying for & updating an NPI Identity & Access User ID will be forwarded to incoming residents & fellows as part of the onboarding process.

Applicant Name: _____

MEDICAL/DENTAL EDUCATION

15. Medical/Dental School				
(Name)		(City)	(State/Country)	
16. Date of Matriculation			17. Date of Graduation	
8. Prior Medical/Dental School (if applicable)				
(Name)		(City)	(State/Country)	(Dates Attended)

RESIDENCY/FELLOWSHIP HISTORY

Specialty	Institution	Location	Dates Served	

ECFMG Registration/Certification (if applicable)

19. ECFMG No.	20. ECFMG Issue Date
----------------------	-----------------------------

EXAMINATION SCORES

Exam Name	Date	Score	City/State	# of Attempts
USMLE STEP 1				
USMLE STEP 2-CK				
USMLE Step 2-CS				
USMLE Step 3				
COMLEX LEVEL 1				
COMLEX LEVEL 2-CE				
COMLEX LEVEL 2-PE				
COMLEX LEVEL 3				

Applicant Name: _____

GRADUATE EDUCATION				
Graduate School Name/City/State/Country	Start Date	End Date	Degree (if any)	Area of Study

UNDERGRADUATE EDUCATION				
Undergraduate School Name/City/State/Country	Start Date	End Date	Degree (if any)	Major

RECORD OF MEDICAL/DENTAL LICENSURE				
List all medical and/or dental licenses issued to you since receiving your medical/dental degree. Include licenses not issued in the United States.				
License	State/Country	License #	Issue Date	Exp.Date
Original License				
Current License				
Other License				
Other License				
Other License				

Have you ever been denied a license, permit, or privilege of taking an examination by any licensing authority? <i>If yes, attach a detailed explanation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a license or permit encumbered in any way (revoked, suspended, surrendered, censored, restricted, limited, placed on probation)? <i>If yes, attach a detailed explanation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been named in a malpractice suit? <i>If yes, attach a detailed explanation.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? <i>If yes, attach statement including date and place of conviction(s) and nature of such offense(s).</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant Name: _____

PERSONAL STATEMENT

(Use additional sheet, if necessary)

Applicant Name: _____

LETTERS OF REFERENCE

List the name, title and institution of those you have requested to write in your behalf.
A minimum of three letters are required.

Signed, original letters—or electronically signed letters—are required. Letters of recommendation must be submitted by the source directly to the UIC training program, and must be not be older than a year.

Name & Title	Institution (Name, City, State/Country)
<u>Ref. #1</u>	
<u>Ref. #2</u>	
<u>Ref. #3</u>	
<u>Ref. #4</u>	

Check One:

- ☐ I hereby waive access to the above letters and will so inform the authors.
☐ I desire access to the above letters and will so inform the authors.

STATE OF HEALTH

Do you have any condition that would preclude you from forming rational judgments, reacting quickly in emergent situations, or working for an extended period of time (i.e., night call) under stressful conditions without interruption? *If yes, attach a detailed explanation.*

- ☐ Yes
☐ No

SERVICE OBLIGATIONS

(Military Service, National Health Service Corps, Armed Forces Scholarship, State Programs, Etc.)

- ☐ I am not required to fulfill any service obligations.
☐ I am committed to fulfill a service obligation beginning _____. No. of years committed: _____

APPLICANT SIGNATURE

I certify that the information on 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 training position or be grounds for termination in case of employment.

Name of Applicant	Signature	Date

This application is intended to be completed, signed and submitted electronically.
You may also print the form and submit the signed & dated original.

Applicant Name: _____

Return application with required attachments to:

Milan Albakri-Micou

Geriatric Medicine Fellowship Program Coordinator

840 S, Wood, Suite

440 Chicago, IL 60612

Email: malbakri@uic.edu

Vania Leung, MD

Geriatric Medicine Fellowship Program Director

840 S, Wood, Suite 440

Chicago, IL 60612

Email: vleung3@uic.edu