GRADUATE MEDICATION EDUCATION RESIDENCY AND FELLOWSHIP APPLICATION 2025-2026

ERAS Code: 1511621091
Proposed Year of Admission:

July 1, 2025

Division of Academic Internal Medicine and Geriatrics
Department of Medicine
University of Illinois at Chicago
840 S. Wood St., 440 CSN (MC 718)
Chicago, IL 60612

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
☐	**1. Residency Application**	
☐	**2. Curriculum Vitae (CV)**	
☐	**3. Personal Statement**	
☐	**4. USMLE Score Sheets or Transcript** (Steps 1, 2-CK *and* 2-CS; or equiv., e.g., COMLEX, NBDE)	
☐	**5. ECFMG Certificate** (International Medical School Graduates Only)	
☐	**6. Medical / Dental School Diploma,** ***if in a foreign language please include official translations.***	
☐	**7. Dean's Letter** (aka "Principal's Letter")	
☐	**8. Medical / Dental School Transcript,** ***if in a foreign language please include official translations.***	
☐	**9. 3 Letters of Recommendation/1 for internal candidates,** ***within 12 months of application*** ☐ 1 – Last Name: ☐ 2 – Last Name: ☐ 3 – Last Name:	1: 2: 3:
☐	**10. Letter of Good Standing*** (only for applicants **currently** in a training program)	
☐	**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.

Updated: 2022.11.11

2025-2026 UIC Application for Fellowship/Residency

UI Health | UIC
Office of Graduate Medical Education

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

PERSONAL INFORMATION			
1. Name (Last) (First) (Middle)			**2. Social Security Number**
3. Citizenship ☐ USA ☐ Other:	**4. Date of Birth**	**5. Place of Birth** (City) (State) (Country)	
6. Gender ☐ Male ☐ Female ☐ 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 ☐ Permanent Resident Alien ☐ J-1 ☐ J-2 ☐ H-1B ☐ F-1 ☐ O-1 ☐ Asylee/Asylum ☐ Temporary Protected Status (TPS) ☐ Other (be specific):	
Yes or No: My *current* visa status includes an Employment Authorization Document (EAD)	☐ **Yes** ☐ **No**
14. Expected Visa Status ☐ Permanent Resident Alien ☐ J-1 ☐ J-2 ☐ H-1B ☐ F-1(OPT) ☐ O-1 ☐ Asylee/Asylum ☐ Temporary Protected Status (TPS) ☐ Other (be specific):	
Yes or No: My *expected* visa status will require an Employment Authorization Document (EAD)	☐ **Yes** ☐ **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? *If yes, attach a detailed explanation.*	☐ **Yes** ☐ **No**
Have you ever had a license or permit encumbered in any way (revoked, suspended, surrendered, censored, restricted, limited, placed on probation)? *If yes, attach a detailed explanation.*	☐ **Yes** ☐ **No**
Have you ever been named in a malpractice suit? *If yes, attach a detailed explanation.*	☐ **Yes** ☐ **No**
Have you ever been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach statement including date and place of conviction(s) and nature of such offense(s).*	☐ **Yes** ☐ **No**

Applicant Name: ______________________________

PERSONAL STATEMENT

(Use additional sheet, if necessary)

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)
Ref. #1	
Ref. #2	
Ref. #3	
Ref. #4	

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.

Return application with required attachments to:

Elizabeth Franco
Geriatric Medicine Fellowship Program Coordinator
840 S, Wood, Suite
440 Chicago, IL 60612
Email: efranco9@uic.edu

Vania Leung, MD
Geriatric Medicine Fellowship Program Director
840 S, Wood, Suite 440
Chicago, IL 60612
Email: vleung3@uic.edu