



THE HARVARD MEDICAL SCHOOL DUBAI CENTER INSTITUTE FOR POSTGRADUATE EDUCATION AND RESEARCH POSTGRADUATE TRAINING PROGRAM

**Application for Training
Deadline: Ongoing**

APPLICATION FORM (all materials sent as part of this application process will be retained by the Fellowship Committee and will not be returned to the applicant). All information should be completed in English and should be typed.

Please contact the HMSDC Fellowship Coordinator at PO Box 66566, Dubai, United Arab Emirates; Phone: +971-4-324-5555, Fax: +971-4-324-9000; fellowship@dhcc.ae if you have questions. The offices of HMSDC are located on the 34th floor of the Emirates Towers Office Building on Shaikh Zayed Road in Dubai.

I. PERSONAL DATA

1. Name in full: _____
(first) (middle) (last)

(previous last name, if applicable)

2. Home address: _____

3. Present address (if different): _____

4. Telephone Number (Work): _____ (Home): _____

5. Page telephone number and beeper number: _____

6. Fax Number: _____

7. E-mail address: _____

8. Marital status: single married divorced widowed

9. Gender: Female Male

10. Date of Birth (MM/DD/YY): _____

11. In case of emergency, notify:
Name: _____ Relation to you: _____

Address: _____

Telephone no.: _____

12. Spoken Languages: _____

13. Citizenship: _____

14. Place of Birth: _____

15. Passport Number: _____

16. Do you currently hold a U.S. Visa? No Yes
If yes, please indicate Visa Type (please include copy, if available):
- B-1, B-2 temporary visitor
 - Diplomatic service
 - F-1 student
 - First Preference
 - H-1, H-1B, H-2, H-3 temporary worker
 - Immigrant
 - J-1, J-2 exchange visitor
 - EAD-employment authorization
 - Other

17. Do you have any disabilities or limitations that would prevent you from performing the responsibilities of this fellowship (including certified cognitive disabilities)?
 No Yes (please explain)

18. Will you need assistance or special accommodations to carry out the responsibilities of a fellow in the specialties and at the specific training programs to which you are applying including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements?
 No Yes (please explain)

19. Do you have military or other such service obligations?
 No Yes (if yes, please explain)

20. Have you been charged with a criminal offense?
 No Yes (if yes, please explain)

21. Have you been treated for substance abuse?
 No Yes (if yes, please explain)

II. EDUCATION, CERTIFICATION, LICENSURE, AND EXPERIENCE

1. For each institution you have attended, please provide the information requested below:

A. Secondary School:

Institution: _____

Location: _____

Dates of attendance: _____

Graduation date: _____

Degree: _____

B. College or University Education (Bachelor or Associate degree):

Institution: _____

Location: _____

Dates of attendance: _____

Graduation date: _____

Major: _____

Degree: _____

C. Postgraduate or University Education (Masters or Doctorate):

Institution: _____

Location: _____

Dates of attendance: _____

Graduation date: _____

Degree: _____

Area of concentration: _____

D. Medical School or University:

Institution: _____

Location: _____

Dates of attendance: _____

Graduation date: _____

Degree: _____

Was your medical education extended or interrupted?

No Yes (if yes, please explain)

Please use this space to list any honors or awards received while in training or during your career:

E. Residency and Internship Training (please list most recent first):

1.

Institution: _____

Location: _____

Dates: _____

Completion date: _____

Type (e.g. pediatrics): _____

US or Canadian board eligible? No Yes

Board certified? No Yes

Name of Board or Professional College: _____

Country of Certification: _____ Date: _____

Certificate No.: _____

2.

Institution: _____

Location: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Completion date: _____

Type (e.g. pediatrics): _____

US or Canadian board eligible? No Yes

Board certified? No Yes

Name of Board or Professional College: _____

Country of Certification: _____ Date: _____

Certificate No.: _____

3.

Institution: _____

Location: _____

Dates: _____

Completion date: _____

Type (e.g. pediatrics): _____

US or Canadian board eligible? No Yes

Board certified? No Yes

Name of Board or Professional College: _____

Country of Certification: _____ Date: _____

Certificate No.: _____

F. Relevant work experience, if applicable (list most recent first)

1.

Organization: _____

Location: _____

Position: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of position & responsibilities: _____

Reason for leaving: _____

2.

Organization: _____

Location: _____

Position: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of position & responsibilities: _____

Reason for leaving: _____

3.

Organization: _____

Location: _____

Position: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of position & responsibilities: _____

Reason for leaving: _____

G. Volunteer experience, if applicable (list most recent first)

1.

Organization: _____

Location: _____

Position: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of position & responsibilities: _____

2.

Organization: _____

Location: _____

Position: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of position & responsibilities: _____

3.

Organization: _____

Location: _____

Position: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of position & responsibilities: _____

1. 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?
 No Yes If yes, please give full details on a separate sheet.

2. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?
 No Yes If yes, please give full details on a separate sheet.

3. Have you ever voluntarily relinquished your license?
 No Yes If yes, please provide full details on a separate sheet.

4. Have you been named as a defendant in a malpractice case?
 No Yes If yes, please provide details on type of case and outcome on a separate sheet.

5. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
 No Yes If yes, please provide full details on a separate sheet.

6. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?
 No Yes If yes, please provide full details on a separate sheet.

7. Please list all jurisdictions in which you have a license to practice medicine. If more than two, please list on a separate sheet.

a.
 Jurisdiction: _____ Country: _____
 License or Ministry Staff Number: _____
 Effective dates: _____

b.
 Jurisdiction: _____ Country: _____
 License or Ministry Staff Number: _____
 Effective dates: _____

8. Have you passed the United States Medical Licensing Exam(s) (USMLE)?
 No Yes If yes, please list scores below and enclose copy of certificate

Step 1 Date: _____ Score: _____
 Step 2 Date: _____ Score: _____

9. Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?
 No Yes If yes, please list certificate number below and enclose copy of certificate

Month: _____ Year: _____ Standard Certificate* No.: _____

10. Are you ACLS (Advanced Cardiac Life Support) certified?
 No Yes If yes, please indicate expiration date below and enclose copy of certificate

Expiration date: _____

11. Are you PALS (Pediatric Advanced Life Support) certified?
 No Yes If yes, please indicate expiration date below and enclose copy of certificate

Expiration date: _____

12. Are you subject to Continuing Medical Education (CME) requirements?
 No Yes

13. If you answered yes to #12, have you fulfilled your CME requirements? Please explain.

III. ENGLISH COMPETENCY

1. English competency:

A. Have you passed the English competency exam?

No Yes If yes, please indicate TOEFL exam information below:

TOEFL Date: _____ Level: _____

B. Did you attend an English language medical school?

No Yes If yes, please complete:

Institution: _____ Country: _____

Dates (MM/DD/YY-MM/DD/YY): _____

C. Have you completed a Residency/Fellowship Program in an English-speaking country?

No Yes If yes, please complete:

Institution: _____ Country: _____

Dates (MM/DD/YY-MM/DD/YY): _____

D. English language references for 1B or 1C:

I. _____

II. _____

III. _____

IV. RESEARCH AND CAREER PLANS

1. Research experience, if applicable (list most recent first):

A.

Organization: _____

Location: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of research: _____

B.

Organization: _____

Location: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of research: _____

C.

Organization: _____

Location: _____

Dates (MM/DD/YY to MM/DD/YY): _____

Description of research: _____

1. 1. Do you plan to take further subspecialty fellowships in the future?
 No Yes If yes, please specify:

2. Do you plan to earn any further degrees in the future?
 No Yes If yes, please specify:

3. Please indicate the training program for which you would like to apply:

Non-Invasive Cardiovascular Imaging Fellowship

Stroke Fellowship

Gastroenterology Fellowship

Maternal Fetal Medicine Fellowship

Orthopedic Trauma Fellowship

Retinal Fellowship

Anterior Segment Fellowship

Sleep Medicine Fellowship

Obstetric Anesthesia Fellowship

Cardiovascular Medicine Fellowship

Other, please indicate preferred subspecialty, duration, and training pathway (clinical fellowship, research fellowship, or observership):

Pediatrics Fellowship

Internal Medicine Training Program

Research Fellowship in Ophthalmology

Gastroenterology Research Fellowship

Diabetes Research Fellowship

Retinal Observership

Anterior Segment Observership

Stem Cell Transplantation Observership

Sleep Medicine Observership

The placement committee will use questions 4-8 below and your personal statement to customize programs for qualified candidates.

4. Why are you interested in this Fellowship/Observership Program?



5. Describe your research interests (if applicable):

6. Describe the position you think you would want after completing the Fellowship/Observership Program.

7. Please provide a succinct statement of your long range career goals .

8. If you have published, please list your publications (articles, books, and/or monographs). Please indicate the single publication which represented your best work by listing it first. You may attach a list of your publications if one is available. Abstracts and publications should be separated.

A.
Title: _____

Authors/presenters: _____

Publication: _____

Month: _____

Year: _____

Volume: _____

Pages: _____

B.
Title: _____

Authors/presenters: _____

Publication: _____

Month: _____

Year: _____

Volume: _____

Pages: _____

C.
Title: _____

Authors/presenters: _____

Publication: _____

Month: _____

Year: _____

Volume: _____

Pages: _____

V. PERSONAL STATEMENT

Please provide additional insight into your applicancy not otherwise reflected (topics that might be relevant include: personal experiences/interests; skills/strengths you would bring to the fellowship/observership, etc.). Please limit the personal statement to this one page.

VI. REFERENCES

Please arrange to have three letters of reference submitted. If applicant is still in training: written recommendation from medical school dean and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant. If applicant has completed training: written recommendation from residency training program director(s) and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant

Letters should be sent directly to: **HMSDC, Fellowship Coordinator, PO Box 66566, Dubai, United Arab Emirates** in an envelope with the author's signature across the seal. Letters that are not written in English should be accompanied by a certified translation of that letter.

Please list the three referring faculty members from whom we can expect to receive letters of reference on your behalf:

1.
Name: _____

Title: _____

Address: _____

E-mail address: _____

Relation to applicant: _____

2.
Name: _____

Title: _____

Address: _____

E-mail address: _____

Relation to applicant: _____

3.
Name: _____

Title: _____

Address: _____

E-mail address: _____

Relation to applicant: _____

++++++
I attest that the information included in this application is true to the best of my knowledge.

(Applicant Signature)

(Date)

Please submit completed application form with supporting documentation along with:

- Recent passport photo
- Current copies of ECFMG certificate (for clinical fellows)
- Copy of current US visa (if available)
- Copy of board certifications or international equivalent (if applicable) in English (official translated copy) or Latin
- If applicant is still in training: written recommendation from medical school dean and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant
- If applicant has completed training: written recommendation from residency training program director(s) and written recommendation from 2 other faculty members who has knowledge of the capacities, abilities, skills, and standing of the applicant
- Official or official certified copy of transcript (in English) from medical school (for clinical and research fellowships only)
- Certified copy of medical school diploma (for clinical and research fellowships only)
- Certified copy of residency certificate (for clinical and research fellowships only)
- Certified copy of fellowship certificate (if applicable)
- USMLE scores (if applicable, required for clinical fellowships)
- TOEFL scores (if applicable)
- Letter of commitment from sponsor
- US \$500 application fee (non-refundable), made payable to Harvard University

If any document has been translated into English, please send the original document along with the certified translation of that document.

Send completed application and enclosures to:

**HMSDC
Fellowship Coordinator
PO Box 66566
Dubai
United Arab Emirates**

For courier delivery:

**HMSDC
Fellowship Coordinator
Emirates Towers Office Building
34th floor
Shaikh Zayed Road
Dubai
United Arab Emirates**

