APPLICATION INSTRUCTIONS

Please save a completed copy of this application and return it as an email attachment, along with your CV (and personal statement if desired), to ewhatley@bwh.harvard.edu.

Letters of recommendation should be addressed to:

Jeffrey L. Schnipper, MD, MPH, MHM
Program Director
Harvard-Brigham Research Fellowship in Hospital Medicine

These letters of recommendation can be submitted as an email attachment to ewhatley@bwh.harvard.edu or mailed to:

Harvard-Brigham Research Fellowship in Hospital Medicine
ATTN: Jeffrey Schnipper, MD, MPH
BWH Division of General Internal Medicine
1620 Tremont St., BC3-2BB
Boston, MA 02120-1613

Applications for Fellowships to begin July 1, 2024 are **due September 15, 2023.** Applications will not be reviewed after the posted deadline.

If you have any questions about the application process, please contact Dr. Jeffrey Schnipper at jschnipper@bwh.harvard.edu or (617) 732-7063.

Due to funding restrictions, applicants are required to be United States citizens or have permanent US resident status.

The program is particularly interested in receiving applications from individuals from underrepresented minority groups. Harvard Medical School and Brigham and Women's Hospital are equal opportunity employers.

HARVARD MEDICAL SCHOOL
BRIGHAM AND WOMEN'S HOSPITAL
Research Fellowship in Hospital Medicine
For Fellowship Beginning July 1, 2024

APPLICATION FORM

Please see instructions on the previous page before completing this application.

I. PERSONAL DATA

1. Name in full (First, Middle Initial, Last): _____

2. Home address: _____

3. Present address (if different): _____

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

   Page Telephone Number and Beeper Number: _____

   Fax Number: _____ E-Mail: _____

5. In case of emergency, notify: _____

6. Date of Birth: _____

7. Last four digits of SSN:_____

8. Are you a citizen of the United States, a non-citizen U.S. national, or Permanent Resident (I-551 or I-151)? Yes ☐ No ☐

9. If you are a graduate of a foreign medical school (except Canada), you are required to be certified by the Educational Council for Foreign Medical Graduates. If you are certified, please indicate below:

Standard Certificate Number: _____

A copy of the certificate must be sent as a PDF file with this application to ewhatley@bwh.harvard.edu or a hard copy can be mailed to:
Harvard-Brigham Research Fellowship in Hospital Medicine
ATTN: Jeffrey Schnipper, MD, MPH
BWH Division of General Medicine
1620 Tremont Street, BC3-2BB
Boston, MA 02120-1613

Date of passing ECFMG exam: _____

10. Do you have any disabilities or limitations that would prevent you from performing the responsibilities of this fellowship? Yes ☐ No ☐

II. EDUCATION, LICENSURE, AND EXPERIENCE

1. High School: Name and location: _____
   Degree and date: _____

2. College: Name and location: _____
   Degree and date: _____

3. Postgraduate: Name and location: _____
   Degree and date: _____

4. Medical School: Name and location: _____
   Degree and date: _____

   Honors? _____

5. Residency and Internship Training (most recent first):

   A. Hospital: _____
      Location: _____
      Date: _____
      Type: _____

   B. Hospital: _____
      Location: _____
      Date: _____
      Type: _____

   C. Hospital: _____
      Location: _____
      Date: _____
      Type: _____

6. Fellowships (most recent first and give specific dates): _____

   Subspecialty Board Certified: _____

7. If you have had a previous fellowship, was it funded by a National Research Service Award (NRSA)? (If you are unsure, please contact the program.)

   Yes ☐ No ☐ If yes, years funded: _____

8. 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?

Yes ☐ No ■ If yes, please give full details on a separate sheet.

9. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?

Yes ☐ No ■ If yes, please give full details on a separate sheet.

10. Have you ever voluntarily relinquished your license?

Yes ☐ No ■ If yes, please give full details on a separate sheet.

11. National and state board examinations (USMLE or equivalent):

Date: _____

State: _____

Number: _____

Pass ☐ Fail ☐

Date: _____

State: _____

Number: _____

Pass ☐ Fail ☐

12. Please tell us how you heard about the fellowship program (check all that apply):

☐ SHM Website

☐ Advertisement in Journal (please specify) _____

☐ Advisor / Mentor (please specify) _____

☐ Friend / Associate (please specify) _____

☐ Other (please specify) _____

III. RESEARCH AND CAREER PLANS

1. Do you plan to pursue a subspecialty fellowship in the future? Yes ☐ No ☐
   Please specify: _____

2. Do you plan to earn any further degrees in the future? Yes ☐ No ☐
   Please specify: _____

3. Why are you interested in this research fellowship in hospital medicine?

4. Describe your research interests (please provide specific details; you may attach a separate page if desired):

5. Describe the position you think you would want after completing the Fellowship Program:

6. Describe your long-term goals:

7. The usual time period for a Fellow to be associated with the Program is two years. If you will require more time, please explain why: _____

8. If you wish, provide any additional information that may be helpful to the Selection Committee (please feel free to attach a separate personal statement): _____

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

Peer reviewed publications in print or other media

Abstracts, Poster Presentations and Exhibits Presented at Professional Meetings

IV. REFERENCES

Please arrange to have three letters of reference submitted. One must be from the Director of your current or most recent clinical training program. List the three individuals from whom we can expect to receive letters of reference on your behalf:

Name: _____

Address: _____

Title: _____

Relationship to applicant: _____

Preferred method of contact: _____

Name: _____

Address: _____

Title: _____

Relationship to applicant: _____

Preferred method of contact: _____

Name: _____

Address: _____

Title: _____

Relationship to applicant: _____

Preferred method of contact: _____

Fellows will start July 1 of each calendar year.

I certify that, to the best of my knowledge and belief, all of my statements are true, correct, complete, and made in good faith.

Candidate Name: _____ Date: _____

(Serves as signature)

HARVARD-BRIGHAM RESEARCH FELLOWSHIP IN HOSPITAL MEDICINE
SELF-IDENTIFICATION FORM

Harvard University is subject to certain governmental recordkeeping and reporting requirement for the administration of civil rights laws and regulations. In order to comply with these laws, Harvard invites its trainees to voluntarily self-identify their ethnicity and race. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Self-Identification of Ethnicity and Race

Do you consider yourself to be Hispanic/Latino?

☐ Yes (A person of Cuban, Chicano, Mexican, Mexican American, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

☐ No

In addition, please select one or more of the following racial categories to describe yourself, if applicable:

☐ American Indian or Alaskan Native (A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliation or community attachment)

☐ Asian, not underrepresented (A person having origins in any of the any of the Asian subpopulations not considered underrepresented in the health professions, including Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai)

☐ Asian, underrepresented: A person having origins in any of the Asian subpopulations considered underrepresented in the health professions, including any Asian OTHER THAN Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai. (i.e., Cambodian, Vietnamese, Malaysian)

☐ Black or African-American (A person having origins in any of the black racial groups of Africa)

☐ Native Hawaiian or Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)

☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa)

Do you identify as a sexual or gender minority (i.e., lesbian, gay, bisexual, or transgender)?

☐ Yes

☐ No

Self-Identification for Veteran Status

As an affirmative action employer, Harvard is subject to certain federal recordkeeping and reporting requirements. In order to assist the University in complying with these requirements, we offer you the opportunity to complete this self-identification form. Submission of this information is voluntary and disclosing or declining to provide it will not subject you to adverse treatment. The information will be used in a manner consistent with federal and state laws.

Please indicate if you are a:

☐ Disabled Veteran: Veteran of the U.S. military who is entitled to compensation (or who but for receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veteran Affairs, or a person who was discharged or released from active duty because of service-connected disability

☐ Recently Separated Veteran: Any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military

☐ Armed Forces Service Medal Vet: Veteran who, while serving on active duty in the U.S. military, participated in a U.S. military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985

☐ Other Protected Veteran: Veteran who served on active duty in the U.S. military during a war or in a campaign or expedition for which a campaign badge has been authorized under laws administered by the Department of Defense

☐ Not a Veteran: None of the above apply

☐ I choose not to self-identify at this time

Self-Identification for Persons with Disabilities

In accordance with Sections 503 and 504 of the Rehabilitation Act of 1973, the provision of this information is on a voluntary basis and will be maintained in a separate location for affirmative action program use and will not be included in the personnel file of any employee for employment.

DEFINITION: DISABILITY STATUS

The following are examples of some, but not all, disabilities which may be included: AIDS, asthma, arthritis, color or visual blindness, cancer, cerebral palsy, deafness or hearing impairment, diabetes, epilepsy, HIV, heart disease, hypertension, learning disabilities, mental or emotional illnesses, multiple sclerosis, muscular dystrophy, orthopedic, speech or visual impairments, or any other physical or mental impairment which substantially limits one or more of your major life activities. Please indicate if you are:

☐ Disabled ☐ Not disabled

Self-Identification for Persons from Disadvantaged Backgrounds

We are required to report the number of individuals applying to, admitted to, and graduated from our program who meet federal definitions for coming from "disadvantaged backgrounds" or "medically underserved communities." The provision of this information is voluntary and will not be included in the personnel file of any employee for employment.

The definition of "Disadvantaged" is that which is currently in use for health professions programs (42 CFR 57.1804 (c)) and includes both economic and educational factors that are barriers to an individual's participation in a health professions program. This means an individual who:

(a) is from an environment that has inhibited the individual from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school, or from a program providing education or training in an allied health profession; or

(b) is from a family with an annual income below a level based on low-income thresholds according to family size, published by the U.S. Bureau of the Census, and adjusted annually for changes in the Consumer Price Index, and by the Secretary for use in health professions programs.

"Medically Underserved community" means an urban or rural population without adequate health care services. If you are unsure about whether your community qualifies, we can use the following geographic information to make that determination:

State: _____

County: _____

City / Town: _____

Please indicate if you believe you are from a:

Disadvantaged Background:	☐ Yes	☐ No	☐ Unsure
Medically Underserved Community:	☐ Yes	☐ No	☐ Unsure
Rural Residential Background:	☐ Yes	☐ No	☐ Unsure

Please use the following link for guidance about rural residential background
https://datawarehouse.hrsa.gov/tools/analyzers/geo/Rural.aspx

Food Restrictions
Please state below is you have any food restrictions (Gluten Intolerant, Kosher, Halal, Vegetarian, etc.) so that we can accommodate your needs if you visit. _____