BayCare Addiction Medicine Fellowship Application Instructions

1. Complete the BayCare Addiction Medicine Application form.

2. Send the following documentation with the application:

   a. Updated Curriculum Vitae. Describe any gaps of more than one month in education or training, if applicable.

   b. Personal Statement describing your interest in Addiction Medicine and plans for future professional work.

   c. Attestations page with your signature.

3. Request a minimum of three letters of reference from faculty members who know you, (one letter must be from your current/most recent Program Director). If you have been in more than one training program, please have those program directors also send letters. Letters must be sent directly to the Addiction Medicine Program Manager: robin.schneider@baycare.org

4. A copy of your Medical School Transcript and Dean's Letter must be sent directly to the Addiction Medicine Program Manager.

5. Send the completed application package to include:

   __Application
   __Personal Statement
   __Attestations page
   __CV

Contact Information:
Robin Schneider, Program Manager
robin.schneider@baycare.org

Common Addiction Medicine
Fellowship Application Form

Date of Application: _____ Anticipated Start Date for Addiction Medicine training: _____

Full Name: _____
Last **First** **Middle**

DOB: _____

Telephone: _____

Email Address: _____

Mailing Address:

_____

_____

Legally eligible to work in the USA? _____ **Visa Status** _____
(Foreign Nationals Only)

Current PG Yr: _____ **PG- level on 7/1/25 start date: _____**

NRMP Participant Code: _____

MDs: List USMLE dates and scores below:

USMLE **Step I** _____ _____ USMLE **Step II** _____ _____
(Date) (Score) (Date) (Score)

USMLE **Step III** _____ _____
(Date) (Score)

DOs: List COMLEX Dates and Scores below:

Level 1 _____ Level 2 _____ Level 3 _____
(Date) (Score) (Date) (Score) (Date) (Score

ECFMG Number and Date _____

Board Certification: If Board Certified, list name of Board and Year of Certification below:

_____

LICENSURE:

Expiration
State _____ Number _____ Date _____ Type_____ Date _____

List NAMES OF REFERENCES: List a minimum of three names, but no more than four.
Please list the names of professionals with whom you have worked and/or studied. Have them send their letter directly to the attention of the Program Director of the Child and Adolescent Psychiatry program, (one of the letters must be from your current Program Director). If you have participated in more than one training program, please have each program director send a letter of reference.

1. _____ 3. _____
(Program Director)

2. _____ 4. _____

Please list any educational or work experiences not already included in your CV

Undergraduate Education: Please provide full name and mailing address for all schools listed.

☐ Please check this box if this information is in your CV and you are intentionally leaving this section blank

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____
Institution Name Street Address

_____
City and State

Graduate Education - (Medical and Masters or Doctoral Program)

☐ Please check this box if this information is in your CV and you are intentionally leaving this section blank

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____

Institution Name Street Address

_____

City and State

Start and End Dates:_____ to _____ List Degree awarded: _____

_____ _____

Institution Name Street Address

_____

City and State

Postgraduate Medical Education:

☐ Please check this box if this information is in your CV and you are intentionally leaving this section blank

INTERNSHIP: (if more than one, please provide additional information on a separate sheet)

Start_____ to _____ ACGME Accredited: _____

(Month/Day/Year) (Month/Day/Year) Yes or □ No

_____ _____

Institution Name Street Address

_____ _____

LIST SPECIALTY City and State

RESIDENCY: (if more than one, please provide additional information on a separate sheet)

Start_____ to _____ ACGME Accredited: _____

(Month/Day/Year) (Month/Day/Year) Yes or □ No

_____ _____

Institution Name Street Address

_____ _____

LIST SPECIALTY City and State

FELLOWSHIP: (if more than one, please provide additional information on a separate sheet)

Start_____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or □ No

_____ _____
Institution Name Street Address

_____ _____
LIST SPECIALTY City and State

OTHER Professional training:

☐ Please check this box if this information is in your CV and you are intentionally leaving this section blank

_____

Start_____ to _____ ACGME Accredited: _____
(Month/Day/Year) (Month/Day/Year) Yes or □ No

_____ _____
Institution Name Street Address

_____ _____
LIST SPECIALTY City and State

☐ Please check this box if you are attaching additional pages

Work Experience

Explain Any Relevant Work Experience During Residency Training:

Explain Research Experience and/or Interests During Residency Training:

Explain any Professional Presentations or Publications During Residency Training:

Explain any Residency Honors / Awards:

Professional Memberships:

Outside Interests / Achievements:

Personal Statement

Describe your interest in Addiction Medicine and explain your plans for future professional work.

Name:_____

Attestations

Circle Yes or No in response to each question below. If you answer "Yes" to any of the questions, please attach a written explanation on a separate page for each question.

Malpractice

Have you received any settlements, malpractice claims, and/or lawsuits, pending or closed, during the previous 10 years?.....Yes No

Miscellaneous

1. Has your professional license in any state ever been revoked, suspended, canceled or restricted?.....Yes No

2. Have you ever been denied a professional license in any state? .....Yes No

3. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge?.....Yes No

4. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? .....Yes No

5. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason? .....Yes No

6. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? .....Yes No

7. Have you ever been convicted of a felony in a criminal action?.....Yes No

Applicant's affidavit:

I certify that all the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment.

Signature of Applicant:_____ Date:_____