Forensic Psychiatry Training
Application Instructions

1. Complete the application form.

2. Send the following documentation with the application: Updated Curriculum Vitae. Describe any gaps of more than one month in education or training, if applicable.

3. Personal Statement describing your interest in forensic psychiatry and plans for future professional work.

4. Attestations page with your signature.

5. Request a minimum of three letters of reference from faculty members, who know you, (one letter must be from your current 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 Training Director.

6. A copy of your Medical School Transcript and Dean’s Letter must be sent directly to the Training Director.

7. Submit a writing sample. This could be a case report, scientific publication, journal article, etc.

8. Mail (or send electronically, if appropriate) the completed application package to include the Application, Personal Statement, Attestations page, writing sample, and your CV.

9. Contact information:
Susan Nobles-Fellowship Coordinator
352-265-3284
snobles@ufl.edu

Brian Cooke, MD-Program Director
352-265-3284
cooke@ufl.edu

UF Health Springhill
Forensic Division / Psychiatry
4037 NW 86th Terrace
Third Floor / Room 3112
Gainesville, FL 32606
Forensic Psychiatry
Fellowship Application Form

Date of Application: ______________ Anticipated Start Date for Forensic training: ______________

Full Name: ____________________________________________________________________________
          Last                              First                              Middle

Current PG Yr: ___________________________ PG- level on start date: __________________________

Present Mailing Address: __________________________________________________________________
 Permanent Mailing Address: __________________________________________________________________


Email Address: __________________________________________________________________________

Place of Birth: __________________________________________________________________________
 DOB: ___________________________

Legally eligible to work in USA? __________ Visa Status ____________________________
(Foreign Nationals Only)

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:

__________________________________________________________________________________________

Forensic Psychiatry Application, revised 1-10-18
LICENSURE:
State ________ Number _____________ Date _____________ Type________ Date _____________

Educational Data

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

**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:

________________________________________________________________________________________

Start____________________ to ________________
(Month/Day/Year) (Month/Day/Year)

ACGME Accredited: ______________________

Yes or □ No

________________________________________________________________________________________

Institution Name

________________________________________________________________________________________

Street Address

________________________________________________________________________________________

LIST SPECIALTY

City and State

☐ Please check this box if you are attaching additional pages
Personal Statement
Describe your interest in Forensic Psychiatry 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:________________________