

APPLICATION PACKET FOR

Bureau of Health Professions

**FACULTY TRAINING PROGRAM IN
GERIATRIC MEDICINE, DENTISTRY, AND
BEHAVIORAL AND MENTAL HEALTH PROFESSIONS**

2001-2003

UCLA Schools of Medicine and Dentistry

Multicampus Program in Geriatric Medicine and Gerontology

Please check appropriate box:

MEDICINE

DENTISTRY

PSYCHIATRY

APPLICATION COVER PAGE

Faculty Training Program
in Geriatric Medicine and Dentistry

**Name of
Applicant**

(Last)

(First)

(Middle)

**Current
Mailing Address**

**Telephone
Numbers**

OFFICE (_____) _____

FAX (_____) _____

HOME (_____) _____

E-Mail _____

**Current
Position**

(Medical or Dental School)

(Department)

(Title)

**Applicant's
Signature**

Date

Application Procedures

One senior fellow in geriatric medicine, one in geriatric dentistry, and one in geriatric psychiatry will be appointed for a two- year fellowship. After receipt and review of applications, top candidates will be invited for personal interviews and for the purpose of examining the program first-hand. The training program commences July 1.

Applications should be submitted to:

David B. Reuben, M.D.
UCLA School of Medicine
Multicampus Program in Geriatric Medicine and Gerontology
10945 Le Conte Avenue, Suite 2339 - BOX 951687
Los Angeles, CA 90095-1687
(310) 825-8253

Applications must include the following items:

1. Application form
2. Curriculum Vitae, including specialty training, certification status and list of publications.
3. Statement of Qualifications and Interest, addressing the following:
 - Why do you wish to participate in the program?
 - The preparation or experience in your background that you believe is relevant to the field of geriatrics and to participation in a geriatrics program.
 - Personal goals of your training years.
 - Specific activities you would like to pursue during the two training years.

Continued on next page

4. Letters of Reference, from your program director and two faculty members discussing your qualifications for undertaking this program in geriatrics. Please list their names below and ask them to submit their letters directly to:

**David B. Reuben, M.D.
UCLA School of Medicine
Multicampus Program in Geriatric Medicine & Gerontology
10945 Le Conte Avenue, Suite 2339 - BOX 951687
Los Angeles, CA 90095-1687**

(1) Name _____

Program Director _____

(2) Name _____

Title _____

Institution _____

(3) Name _____

Title _____

Institution _____

5. Application Cover Page

(Thank you)

Faculty Development in Geriatric Medicine, Dentistry or Psychiatry

APPLICATION FORM

NAME _____

I am (please check one):

_____ a US citizen

_____ a non-citizen national

_____ a foreign national having a visa permitting permanent residence in
the US

I have completed graduate medical training in:

_____ internal medicine

_____ family medicine

_____ psychiatry

I have completed a fellowship in :

_____ geriatrics

_____ geropsychiatry

or

_____ I have completed a postdoctoral dental education program or a minimum of
2 years of clinical practice of which at least 12 months were devoted to
managing older dental patients.

Please indicate any previous experience working with underserved populations (i.e.
Hispanic serving institutions, Historical Black colleges and Universities and Tribal Colleges
and Universities serving Native Americans)
