

**Women & Infants Hospital Fellowship in
Women's Mental Health**

Center for Women's Behavioral Health
2 Dudley Street
Providence, RI 02905

Fellowship Application

Applicant Information

Name: Last: _____ First: _____ MI: _____ DOB: _____

Street Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Citizenship: United States Other please specify: _____

If no, are you authorized to work in the United States? Yes No

Type of Visa presently held: _____ Expiration: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: White Hispanic or Latino Black or African American American Indian or Alaskan Native Asian Native Hawaiian or other Pacific Islander Other

Medical School

Name: _____ Degree(s): _____ Dates Attended: _____

Graduate Medical Training

Residency: _____ Dates: _____

Additional Training: _____

Honors/Awards:

Board Certification Status:

ABPN Eligible: Yes No

ABPN Certified: Yes No Year of Certification:

What influenced your interest in women's mental health? *(Please limit your answers to 200 words)*

Please describe your prior experience in women's mental health: *(Please limit your answers to 200 words)*

What led you to be interested in this fellowship program in particular? *(Please limit your answers to 200 words)*

With this application, please attach an updated Curriculum Vitae, and Letter of Interest/Personal Statement (not to exceed one typed page). Please have 3 letters of professional reference including one from your program director forwarded under separate cover.

RETURN TO: Lauren Del Vecchio, Women & Infants Hospital, Suite 3352, 101 Dudley Street, Providence, RI 02905 ldelvecchio@wihri.org

Signature :

Date :
