Kaiser Permanente Southern California
Community Medicine Fellowship Application

INSTRUCTIONS

Eligibility requirements:

- Graduation from an ACGME-accredited residency program
- Successful completion of USMLE/COMLEX Boards
- California Medical License
- DEA certificate
- Other specialty-specific licenses (see the program website for details)
- Clearance of Kaiser Permanente employment screenings

The following items must be submitted before your file can be reviewed for consideration:

☐ Completed Application

☐ Personal Statement

☐ Curriculum Vitae

☐ One (1) letter of recommendation from your Residency Program Director

☐ Two (2) additional professional letters of recommendation

☐ USMLE / COMLEX Transcript

☐ Medical School Transcript

☐ MSPE (Dean's Letter)

Submit application materials to Rachel.L.Hollander@kp.org

For additional questions please contact:
Rachel Hollander
Program Administrator
Center for Medical Education
4733 W Sunset Blvd, 3rd Fl
Los Angeles, CA 90027
(323) 783-1433

INFORMATION

Position beginning: ☐ 2013 ☐ 2014 ☐ 2015

Fellowship Requested (check all that apply):

☐ Family Medicine – Orange County
☐ Family Medicine – Fontana
☐ Family Medicine – Woodland Hills
☐ Family Medicine – Los Angeles
☐ Internal Medicine – Los Angeles
☐ Pediatrics – Los Angeles

Applicant name: ______________________ ______________________ _____
Last First MI

Other names used: ______________________ ______________________ _____
Last First MI

Current address: ____
Street Address

______________________ ________________ __________
City State Zip

Permanent address: ____
(if different than above) Street Address

______________________ ________________ __________
City State Zip

E-mail Address: ______________________________

Cell phone #: ______________________________ Alternate contact #: ______________________________

Social Security #: __ __ __ – __ __ – __ __ __ __ Citizenship: ______________________________

Date of birth: __ __ / __ __ / __ __ __ __ If not US, current visa: ______________________________
M M D D Y Y Y Y

Have you previously participated at any Kaiser Permanente facility as a medical student, volunteer, resident, fellow, per diem physician, or staff member? ☐ Yes
☐ No

If yes, please complete the following information:

Role: ______________________________ KP Facility (City, State): ______________________________

Dates: ______________________________ Department: ______________________________

NUID (if applicable): ____________________

EDUCATIONAL HISTORY

A) RESIDENCY / FELLOWSHIP EXPERIENCE

Specialty: ______________________________ Institution: ____________________________________

Start Date: __ __ / __ __ (M M / Y Y) Completion Date: __ __ / __ __ (M M / Y Y)

Program Director: ____

Phone #: ______________________________ E-mail: _______________________________________

____
Street Address

________________________________ __________________ ___________ __________________
City State Zip Country

Specialty: ______________________________ Institution: ____________________________________

Start Date: __ __ / __ __ (M M / Y Y) Completion Date: __ __ / __ __ (M M / Y Y)

Program Director: ____

Phone #: ______________________________ E-mail: _______________________________________

____
Street Address

________________________________ __________________ ___________ __________________
City State Zip Country

Specialty: ______________________________ Institution: ____________________________________

Start Date: __ __ / __ __ (M M / Y Y) Completion Date: __ __ / __ __ (M M / Y Y)

Program Director: ____

Phone #: ______________________________ E-mail: _______________________________________

____
Street Address

________________________________ __________________ ___________ __________________
City State Zip Country

B) MEDICAL EDUCATION

Institution: ______________________________

From: __ __ / __ __ (M M / Y Y) To: __ __ / __ __ (M M / Y Y)

______________________________ Street Address ____________ State ________ Country

For International Medical Graduates: ECFMG #: ______________
If applicable, please attach a copy of ECFMG certificate with your application.

C) GRADUATE EDUCATION

Institution: ______________________________ Major: ______________

From: __ __ / __ __ (M M / Y Y) To: __ __ / __ __ (M M / Y Y) Degree: ______________

______________________________ Street Address ____________ State ________ Country

Institution: ______________________________ Major: ______________

From: __ __ / __ __ (M M / Y Y) To: __ __ / __ __ (M M / Y Y) Degree: ______________

______________________________ Street Address ____________ State ________ Country

D) UNDERGRADUATE EDUCATION

Institution: ______________________________ Major: ______________

From: __ __ / __ __ (M M / Y Y) To: __ __ / __ __ (M M / Y Y) Degree: ______________

______________________________ Street Address ____________ State ________ Country

Institution: ______________________________ Major: ______________

From: __ __ / __ __ (M M / Y Y) To: __ __ / __ __ (M M / Y Y) Degree: ______________

______________________________ Street Address ____________ State ________ Country

EXAMINATIONS

List the scores for the examinations you have completed:

USMLE Step 1 ___________ COMLEX Level 1 _________

USMLE Step 2 ___________ COMLEX Level 2 _________

USMLE Step 3 ___________ COMLEX Level 3 _________

Do any of the scores above reflect multiple examination attempts? ☐ Yes ☐ No

If yes, please specify test and number of attempts:

Board Certification:

☐ Passed the Board Exam.

Specialty _______________________________ Date ____________________

☐ Currently eligible for Board Certification.

☐ Will be eligible as of July 1, 20______ (upon completion of ACGME-accredited residency program).

☐ Not eligible.

LICENSES

Do you have a California Medical License? ☐ Yes ☐ No License #: _______________ Expiration: _______________

If not, have you applied for one? ☐ Yes ☐ No Date applied: _____________

List any other states in which you are licensed to practice medicine.

STATE	LICENSE #	DATE ISSUED	EXPIRATION

Do you have a DEA Registration? ☐ Yes ☐ No DEA #: _________________ Expiration: _______________

REFERENCES

List three references that will be submitting letters (one must be your residency program director).

NAME	TITLE	E-MAIL / PHONE #

ADDITIONAL INFORMATION

If you have published, please indicate the single publication representative of your best work.
Provide a full list of publications and abstracts in your CV.

Describe your current community and/or research interests.

Describe a personal experience in community health care that was particularly meaningful for you.

Describe your ideal position after completing the Fellowship Program.

How were you referred to the Kaiser Permanente Southern California Community Medicine Fellowship?
Check all that apply.

☐ Advertisement ☐ KP website ☐ Academy website

☐ Colleague referral ☐ Conference ☐ Other: ______________________________

I certify that the information provided in the application as well as submitted materials are truthful and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me for this position. I further declare that by submitting this application, I authorize Kaiser Permanente and its representatives to contact persons associated with hospitals or institutions at which I have studied or trained as well as individuals whose names I have submitted in connection with this application. I hereby release from any liability all representatives of the hospital and its professional staff for information provided in connection with evaluating my application, suitability for employment or training, and credentials.

Signature ____ SIGN HERE Date ______________________