



MOUNT SINAI
SCHOOL OF
MEDICINE
NEW YORK

Brookdale Department of Geriatrics and Adult Development
Mount Sinai School of Medicine
**CERTIFICATE PROGRAM IN GERIATRIC MEDICINE
FOR VISITING PHYSICIANS**

APPLICATION

One Gustave L. Levy Place, New York, New York 10029

APPLICATION FOR THE ACADEMIC PROGRAM
IN THE MEDICAL SPECIALTIES FOR VISITING PHYSICIANS

Date of Application _____

Name _____ DOB _____

First Middle Last

Mailing Address _____

Street

City Country Telephone

Permanent Address _____

Street

City Country Telephone

E-mail Address _____

Male _____ Female _____ Country of Citizenship _____

Country of Birth _____

Name of Clinical Service desired

Dates desired (beginning and ending) _____

UNDERGRADUATE MEDICAL SCHOOL DATES ATTENDED DEGREE

To
To
To

Hospital Experience

NAME AND LOCATION DATES ATTENDED SERVICE

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Languages Spoken: _____

Educational Commission for Foreign Medical Graduates (ECFMG) # _____

(If applicable)

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Are you now licensed in your home country? _____

License # _____ Country _____

Letters of recommendation from persons under whom you have worked and studied in the institutions you have named above should be sent to the Chief of Service to whom the application is being made.

APPLICANT'S AFFIDAVIT:

I certify that 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 rejection of this application or for dismissal after my appointment. I hereby authorize my present/past employers to furnish Mount Sinai with their records of service. I agree, if appointed, to supply Mount Sinai with such verifications as they may be permitted by Federal, State and Municipal Codes and Regulations to request of me and to abide by all Mount Sinai's rules and regulations.

DATE SIGNATURE

This application must be accompanied by:

**1)
A notarized copy of your medical school diploma in original language and English translation (both versions MUST be notarized)**

**2)
An original Dean's Letter in English from your medical school on school stationery or a notarized copy**

**3)
An original letter of recommendation in English from your residency training program director on school stationery or a notarized copy**

**4)
Proof of health insurance coverage while in the U.S. in English**

**5)
A notarized copy of licensure from home country in original language and English (both versions MUST be notarized)**

For Official Use Only

Credentials Verified Yes _____ No _____

Signature _____ Date Approved _____