



**THE HARVARD MEDICAL SCHOOL DUBAI CENTER INSTITUTE FOR POSTGRADUATE EDUCATION AND RESEARCH POSTGRADUATE TRAINING PROGRAM**

**Application for Training  
Deadline: Ongoing**

**APPLICATION FORM** (all materials sent as part of this application process will be retained by the Fellowship Committee and will not be returned to the applicant). All information should be completed in English and should be typed.

Please contact: Harvard Medical School Dubai Center, Dubai Healthcare City, P.O. Box 505002, Dubai, United Arab Emirates; Phone: +9714 3622743, Fax: +971-4-324-9000; please email [info-hmsdc@hms.harvard.edu](mailto:info-hmsdc@hms.harvard.edu) if you have questions.

**I. PERSONAL DATA**

1. Name in full: \_\_\_\_\_  
(first) (middle) (last)  
\_\_\_\_\_  
(previous last name, if applicable)
2. Home address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Present address (if different): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Telephone Number (Work): \_\_\_\_\_ (Home): \_\_\_\_\_
5. Page telephone number and beeper number: \_\_\_\_\_
6. Fax Number: \_\_\_\_\_
7. E-mail address: \_\_\_\_\_
8. Marital status:  single  married  divorced  widowed
9. Gender:  Female  Male
10. Date of Birth (MM/DD/YY): \_\_\_\_\_
11. In case of emergency, notify:  
Name: \_\_\_\_\_ Relation to you: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone no.: \_\_\_\_\_
12. Spoken Languages: \_\_\_\_\_  
\_\_\_\_\_
13. Citizenship: \_\_\_\_\_
14. Place of Birth: \_\_\_\_\_
15. Passport Number: \_\_\_\_\_

16. Do you currently hold a U.S. Visa?  No  Yes  
If yes, please indicate Visa Type (please include copy, if available):
- B-1, B-2 temporary visitor
  - Diplomatic service
  - F-1 student
  - First Preference
  - H-1, H-1B, H-2, H-3 temporary worker
  - Immigrant
  - J-1, J-2 exchange visitor
  - EAD-employment authorization
  - Other

17. Do you have any disabilities or limitations that would prevent you from performing the responsibilities of this fellowship (including certified cognitive disabilities)?  
 No  Yes (please explain)

18. Will you need assistance or special accommodations to carry out the responsibilities of a fellow in the specialties and at the specific training programs to which you are applying including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements?  
 No  Yes (please explain)

19. Do you have military or other such service obligations?  
 No  Yes (if yes, please explain)

20. Have you been charged with a criminal offense?  
 No  Yes (if yes, please explain)

21. Have you been treated for substance abuse?  
 No  Yes (if yes, please explain)

**II. EDUCATION, CERTIFICATION, LICENSURE, AND EXPERIENCE**

1. For each institution you have attended, please provide the information requested below:

A. Secondary School:

Institution: \_\_\_\_\_

Location: \_\_\_\_\_

Dates of attendance: \_\_\_\_\_

Graduation date: \_\_\_\_\_

Degree: \_\_\_\_\_

**B. College or University Education (Bachelor or Associate degree):**

Institution: \_\_\_\_\_  
Location: \_\_\_\_\_  
Dates of attendance: \_\_\_\_\_  
Graduation date: \_\_\_\_\_  
Major: \_\_\_\_\_  
Degree: \_\_\_\_\_

**C. Postgraduate or University Education (Masters or Doctorate):**

Institution: \_\_\_\_\_  
Location: \_\_\_\_\_  
Dates of attendance: \_\_\_\_\_  
Graduation date: \_\_\_\_\_  
Degree: \_\_\_\_\_  
Area of concentration: \_\_\_\_\_

**D. Medical School or University:**

Institution: \_\_\_\_\_  
Location: \_\_\_\_\_  
Dates of attendance: \_\_\_\_\_  
Graduation date: \_\_\_\_\_  
Degree: \_\_\_\_\_

Was your medical education extended or interrupted?  
 No       Yes (if yes, please explain)

Please use this space to list any honors or awards received while in training or during your career:

**E. Residency and Internship Training (please list most recent first):**

**1.**  
Institution: \_\_\_\_\_  
Location: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Completion date: \_\_\_\_\_  
Type (e.g. pediatrics): \_\_\_\_\_  
US or Canadian board eligible?  No  Yes  
Board certified?  No  Yes  
Name of Board or Professional College: \_\_\_\_\_  
Country of Certification: \_\_\_\_\_ Date: \_\_\_\_\_  
Certificate No.: \_\_\_\_\_

**2.**  
Institution: \_\_\_\_\_  
Location: \_\_\_\_\_  
Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_  
Completion date: \_\_\_\_\_  
Type (e.g. pediatrics): \_\_\_\_\_  
US or Canadian board eligible?  No  Yes  
Board certified?  No  Yes  
Name of Board or Professional College: \_\_\_\_\_  
Country of Certification: \_\_\_\_\_ Date: \_\_\_\_\_  
Certificate No.: \_\_\_\_\_

**3.**  
Institution: \_\_\_\_\_  
Location: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Completion date: \_\_\_\_\_  
Type (e.g. pediatrics): \_\_\_\_\_  
US or Canadian board eligible?  No  Yes  
Board certified?  No  Yes  
Name of Board or Professional College: \_\_\_\_\_  
Country of Certification: \_\_\_\_\_ Date: \_\_\_\_\_

Certificate No.: \_\_\_\_\_

**F. Relevant work experience, if applicable (list most recent first)**

**1.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**2.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**3.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**G. Volunteer experience, if applicable (list most recent first)**

**1.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

**2.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

**3.**

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Position: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of position & responsibilities: \_\_\_\_\_

1. Have your privileges at any hospital or other facility ever been denied, limited, suspended, revoked, or not renewed? And/or have you ever been denied membership or a renewal therein or been subjected to disciplinary proceedings in any hospital or medical organization?  
 No       Yes    If yes, please give full details on a separate sheet.

2. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?  
 No       Yes    If yes, please give full details on a separate sheet.

3. Have you ever voluntarily relinquished your license?  
 No       Yes    If yes, please provide full details on a separate sheet.

4. Have you been named as a defendant in a malpractice case?  
 No       Yes    If yes, please provide details on type of case and outcome on a separate sheet.

5. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?  
 No       Yes    If yes, please provide full details on a separate sheet.

6. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?  
 No       Yes    If yes, please provide full details on a separate sheet.

7. Please list all jurisdictions in which you have a license to practice medicine. If more than two, please list on a separate sheet.

a.  
 Jurisdiction: \_\_\_\_\_ Country: \_\_\_\_\_  
 License or Ministry Staff Number: \_\_\_\_\_  
 Effective dates: \_\_\_\_\_

b.  
 Jurisdiction: \_\_\_\_\_ Country: \_\_\_\_\_  
 License or Ministry Staff Number: \_\_\_\_\_  
 Effective dates: \_\_\_\_\_

8. Have you passed the United States Medical Licensing Exam(s) (USMLE)?  
 No  Yes If yes, please list scores below and enclose copy of certificate

Step 1                      Date: \_\_\_\_\_                      Score: \_\_\_\_\_  
 Step 2                      Date: \_\_\_\_\_                      Score: \_\_\_\_\_

9. Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?  
 No  Yes If yes, please list certificate number below and enclose copy of certificate

Month: \_\_\_\_\_ Year: \_\_\_\_\_ Standard Certificate\* No.: \_\_\_\_\_

10. Are you ACLS (Advanced Cardiac Life Support) certified?  
 No  Yes If yes, please indicate expiration date below and enclose copy of certificate

Expiration date: \_\_\_\_\_

11. Are you PALS (Pediatric Advanced Life Support) certified?  
 No  Yes If yes, please indicate expiration date below and enclose copy of certificate

Expiration date: \_\_\_\_\_

12. Are you subject to Continuing Medical Education (CME) requirements?  
 No  Yes

13. If you answered yes to #12, have you fulfilled your CME requirements? Please explain.

**III. ENGLISH COMPETENCY**

1. English competency:

A. Have you passed the English competency exam?

No  Yes If yes, please indicate TOEFL exam information below:

TOEFL Date: \_\_\_\_\_ Level: \_\_\_\_\_

B. Did you attend an English language medical school?

No  Yes If yes, please complete:

Institution: \_\_\_\_\_ Country: \_\_\_\_\_

Dates (MM/DD/YY-MM/DD/YY): \_\_\_\_\_

C. Have you completed a Residency/Fellowship Program in an English-speaking country?

No  Yes If yes, please complete:

Institution: \_\_\_\_\_ Country: \_\_\_\_\_

Dates (MM/DD/YY-MM/DD/YY): \_\_\_\_\_

D. English language references for 1B or 1C:

I. \_\_\_\_\_

II. \_\_\_\_\_

III. \_\_\_\_\_

**IV. RESEARCH AND CAREER PLANS**

1. Research experience, if applicable (list most recent first):

A.

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of research: \_\_\_\_\_

B.

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of research: \_\_\_\_\_

C.

Organization: \_\_\_\_\_

Location: \_\_\_\_\_

Dates (MM/DD/YY to MM/DD/YY): \_\_\_\_\_

Description of research: \_\_\_\_\_

1. 1. Do you plan to take further subspecialty fellowships in the future?  
 No  Yes If yes, please specify:

2. Do you plan to earn any further degrees in the future?  
 No  Yes If yes, please specify:

3. Please indicate the training program for which you would like to apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Non-Invasive Cardiovascular Imaging Fellowship   | <input type="checkbox"/> Pediatrics Fellowship                  |
| <input type="checkbox"/> Stroke Fellowship  | <input type="checkbox"/> Internal Medicine Training Program     |
| <input type="checkbox"/> Gastroenterology Fellowship  | <input type="checkbox"/> Research Fellowship in Ophthalmology   |
| <input type="checkbox"/> Maternal Fetal Medicine Fellowship   | <input type="checkbox"/> Gastroenterology Research Fellowship   |
| <input type="checkbox"/> Orthopedic Trauma Fellowship   | <input type="checkbox"/> Diabetes Research Fellowship           |
| <input type="checkbox"/> Retinal Fellowship   | <input type="checkbox"/> Retinal Observership                   |
| <input type="checkbox"/> Anterior Segment Fellowship  | <input type="checkbox"/> Anterior Segment Observership          |
| <input type="checkbox"/> Sleep Medicine Fellowship  | <input type="checkbox"/> Stem Cell Transplantation Observership |
| <input type="checkbox"/> Obstetric Anesthesia Fellowship  | <input type="checkbox"/> Sleep Medicine Observership            |
| <input type="checkbox"/> Cardiovascular Medicine Fellowship   |   |
| <input type="checkbox"/> Other, please indicate preferred subspecialty, duration, and training pathway (clinical fellowship, research fellowship, or observership): |   |

The placement committee will use questions 4-8 below and your personal statement to customize programs for qualified candidates.

4. Why are you interested in this Fellowship/Observership Program?



5. Describe your research interests (if applicable):

6. Describe the position you think you would want after completing the Fellowship/Observership Program.

7. Please provide a succinct statement of your long range career goals .

8. If you have published, please list your publications (articles, books, and/or monographs). Please indicate the single publication which represented your best work by listing it first. You may attach a list of your publications if one is available. Abstracts and publications should be separated.

A.  
Title: \_\_\_\_\_

Authors/presenters: \_\_\_\_\_

Publication: \_\_\_\_\_

Month: \_\_\_\_\_

Year: \_\_\_\_\_

Volume: \_\_\_\_\_

Pages: \_\_\_\_\_

B.  
Title: \_\_\_\_\_

Authors/presenters: \_\_\_\_\_

Publication: \_\_\_\_\_

Month: \_\_\_\_\_

Year: \_\_\_\_\_

Volume: \_\_\_\_\_

Pages: \_\_\_\_\_

C.  
Title: \_\_\_\_\_

Authors/presenters: \_\_\_\_\_

Publication: \_\_\_\_\_

Month: \_\_\_\_\_

Year: \_\_\_\_\_

Volume: \_\_\_\_\_

Pages: \_\_\_\_\_

**V. PERSONAL STATEMENT**

Please provide additional insight into your applicancy not otherwise reflected (topics that might be relevant include: personal experiences/interests; skills/strengths you would bring to the fellowship/observership, etc.). Please limit the personal statement to this one page.

**VI. REFERENCES**

Please arrange to have three letters of reference submitted. If applicant is still in training: written recommendation from medical school dean and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant. If applicant has completed training: written recommendation from residency training program director(s) and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant

Letters should be sent directly to: **Harvard Medical School Dubai Center, Dubai Healthcare City, P.O. Box 505002, Dubai, United Arab Emirates** in an envelope with the author's signature across the seal. Letters that are not written in English should be accompanied by a certified translation of that letter.

Please list the three referring faculty members from whom we can expect to receive letters of reference on your behalf:

1.  
Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relation to applicant: \_\_\_\_\_

2.  
Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relation to applicant: \_\_\_\_\_

3.  
Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relation to applicant: \_\_\_\_\_

++++  
I attest that the information included in this application is true to the best of my knowledge.

\_\_\_\_\_  
(Applicant Signature)

\_\_\_\_\_  
(Date)



**Please submit completed application form with supporting documentation along with:**

- Recent passport photo
- Current copies of ECFMG certificate (for clinical fellows)
- Copy of current US visa (if available)
- Copy of board certifications or international equivalent (if applicable) in English (official translated copy) or Latin
- If applicant is still in training: written recommendation from medical school dean and written recommendation from 2 other faculty members who have knowledge of the capacities, abilities, skills, and standing of the applicant
- If applicant has completed training: written recommendation from residency training program director(s) and written recommendation from 2 other faculty members who has knowledge of the capacities, abilities, skills, and standing of the applicant
- Official or official certified copy of transcript (in English) from medical school (for clinical and research fellowships only)
- Certified copy of medical school diploma (for clinical and research fellowships only)
- Certified copy of residency certificate (for clinical and research fellowships only)
- Certified copy of fellowship certificate (if applicable)
- USMLE scores (if applicable, required for clinical fellowships)
- TOEFL scores (if applicable)
- Letter of commitment from sponsor
- US \$500 application fee (non-refundable), made payable to Harvard University

If any document has been translated into English, please send the original document along with the certified translation of that document.

**Send completed application and enclosures to:**

**Harvard Medical School Dubai Center  
Dubai HealthCare City  
P.O. Box 505002  
Dubai,  
United Arab Emirates  
Phone: +9714 3622743**

