



Psychiatric
Research Institute

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
CHILD STUDY CENTER
1210 WOLFE STREET, SLOT 654
LITTLE ROCK, AR 72202
501.364.1992
BDBentley@uams.edu

CHILD AND ADOLESCENT PSYCHIATRY FELLOWSHIP TRAINING PROGRAM APPLICATION

GENERAL INFORMATION

*PLEASE PROVIDE DETAILED ANSWERS WHEN REQUIRED AND INCLUDE ADDITIONAL DOCUMENTATION AS NEEDED

FULL NAME	
PREFERRED NAME	
MAILING ADDRESS	
EMAIL	
PHONE NUMBER	
GENDER	
BIRTH DATE	
BIRTH PLACE	
CITIZENSHIP	
CURRENT VISA/EMPLOYMENT AUTHORIZATION STATUS	
EXPECTED VISA/EMPLOYMENT AUTHORIZATION STATUS	
AAMC ID	
USMLE ID	
NBOME ID	
NRMP ID	
PARTICIPATING IN THE NRMP MATCH (YES/NO)	
PARTICIPATING AS A COUPLE IN THE MATCH (YES/NO)	
MILITARY SERVICE OBLIGATION DEFERMENT? (YES/NO)	
OTHER SERVICE OBLIGATION(S)?	
MISDEMEANOR CONVICTION IN THE UNITED STATES? (IF YES, PLEASE EXPLAIN)	
FELONY CONVICTION IN THE UNITED STATES? (IF YES, PLEASE EXPLAIN)	
LANGUAGE FLUENCY (LIST ALL LANGUAGES SPOKEN FLUENTLY)	



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DO YOU HAVE ANY PHYSICAL OR EMOTIONAL PROBLEMS THAT MIGHT AFFECT YOUR PERFORMANCE AS A PHYSICIAN? IF YES, PLEASE EXPLAIN

MEDICAL LICENSURE

ACLS (YES/NO; IF YES, EXPIRATION DATE)	
PALS (YES/NO; IF YES, EXPIRATION DATE)	
BLS (YES/NO; IF YES, EXPIRATION DATE)	
DEA REGISTRATION NUMBER; EXPIRATION DATE	
BOARD CERTIFICATION	
MEDICAL LICENSURE SUSPENDED/REVOKED/VOLUNTARILY TERMINATED? (IF YES, PLEASE EXPLAIN)	
EVER NAMED IN A MALPRACTICE SUIT? (IF YES, PLEASE EXPLAIN)	

STATE MEDICAL LICENSES

<u>TYPE (FULL, RESTRICTED, ETC.)</u>	<u>NUMBER</u>	<u>STATE</u>	<u>EXPIRATION DATE</u>



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CURRENT/PRIOR RESIDENCY TRAINING

<u>INSTITUTION AND LOCATION</u>	<u>DATES ATTENDED</u>	<u>DEGREE</u>	<u>DATE OF DEGREE</u>
<u>REASON FOR LEAVING</u>			

<u>INSTITUTION AND LOCATION</u>	<u>DATES ATTENDED</u>	<u>DEGREE</u>	<u>DATE OF DEGREE</u>
<u>REASON FOR LEAVING</u>			

MEDICAL EDUCATION/INSTITUTION

<u>INSTITUTION AND LOCATION</u>	<u>DATES ATTENDED</u>	<u>DEGREE</u>	<u>DATE OF DEGREE</u>
<u>MEDICAL EDUCATION/TRAINING EXTENDED OR INTERRUPTED? IF YES, PLEASE EXPLAIN</u>			

MEDICAL SCHOOL/RESIDENCY HONORS AND AWARDS

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EDUCATION

<u>LEVEL</u>	<u>INSTITUTION AND LOCATION</u>	<u>DATES ATTENDED</u>	<u>DEGREE</u>	<u>DATE OF DEGREE</u>	<u>FIELD OF STUDY</u>
UNDERGRADUATE:					
GRADUATE:					
OTHER:					

OTHER AWARDS/ACCOMPLISHMENTS

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MEMBERSHIP IN HONORARY/PROFESSIONAL SOCIETIES

--

HOBBIES AND INTERESTS

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EXPERIENCE

**FOR THE SECTIONS BELOW, PLEASE SPECIFY ORGANIZATION AND LOCATION, POSITION, DATES ATTENDED, SUPERVISOR, AVERAGE HOURS SPENT PER WEEK, JOB RESPONSIBILITIES, AND REASON FOR LEAVING*

WORK

RESEARCH

VOLUNTEER

PUBLICATIONS

PEER-REVIEWED JOURNAL ARTICLES/ABSTRACTS

POSTER/ORAL PRESENTATIONS