



**NATHAN ADELSON HOSPICE
FELLOWSHIP IN HOSPICE AND PALLIATIVE MEDICINE
APPLICATION PROCESS**

Thank you for your interest in the Nathan Adelson Hospice (NAH) Fellowship Program. NAH is known for its quality care and compassionate support of terminally ill patients and their loved ones. This fine reputation is a direct result of the ongoing commitment to excellence and the dedication of our staff and volunteers.

In order to apply for the NAH Fellowship in Hospice and Palliative Medicine, please provide the following:

- A completed and signed application
- Curriculum Vitae
- Two or more physician reference letters, a minimum of one from an osteopathic physician
- A reference from the Program Director of your residency

Please send the application packet via email to cfarris@nah.org or via fax (702) 796-3122.

This is an exciting time in your life, and one that offers many opportunities for continued growth. We look forward to our potential relationship and hope that your association with NAH will prove to be a rewarding and satisfying experience.



FELLOWSHIP BEGINNING IN : _____ (Year)		
1. NAME (LAST) (FIRST) (MIDDLE)	2. SOCIAL SECURITY NUMBER - -	
3. PRESENT ADDRESS (STREET)		
(CITY)	(STATE)	(ZIP)
4. PRESENT PHONE NOS. (DAY)	(EVENING)	
5. PERMANENT ADDRESS: C/O (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED)		
(STREET)		
(CITY)	(STATE)	(ZIP)
6. PERMANENT PHONE NOS. (DAY)	(EVENING)	
7. CITIZENSHIP <input type="checkbox"/> U.S. <input type="checkbox"/> OTHER (PLEASE STATE) _____	8. VISA STATUS (IF APPLICABLE) <input type="checkbox"/> PERMANENT <input type="checkbox"/> J-1 <input type="checkbox"/> TEMPORARY – SPECIFY: <input type="checkbox"/> H-1	
9. SERVICE OBLIGATIONS (NATIONAL HEALTH SERVICE CORPS, ARMED FORCES SCHOLARSHIP, STATE PROGRAMS, ETC.) <input type="checkbox"/> I AM NOT REQUIRED TO FULFILL ANY SERVICE OBLIGATIONS <input type="checkbox"/> I AM COMMITTED TO FULFILL A SERVICE OBLIGATION BEGINNING : _____ (MO/YR) NUMBER OF YEARS COMMITTED: _____		
CURRENT/PRIOR TRAINING		
10. A. INSTITUTION/PROGRAM		
(CITY)	(STATE/COUNTRY)	
11. TYPE OF TRAINING	12. SPECIALTY	
13. PROGRAM DIRECTOR (NAME)		
14. SUPERVISOR (NAME)		
15. DATES OF TRAINING (FROM MO/YR TO MO/YR)		

CURRENT/PRIOR TRAINING (cont.)

16. B. INSTITUTION/PROGRAM

(CITY)

(STATE/COUNTRY)

17. TYPE OF TRAINING

18. SPECIALTY

19. PROGRAM DIRECTOR (NAME)

20. SUPERVISOR (NAME)

21. DATES OF TRAINING (FROM MO/YR TO MO/YR)

MEDICAL EDUCATION

22. MEDICAL SCHOOL(S) (NAME)

(CITY)

(STATE/COUNTRY)

23. DATES OF ATTENDANCE (FROM MO/YR TO MO/YR)

24. DEGREE

25. DEGREE MONTH/YEAR

UNDERGRADUATE AND GRADUATE EDUCATION

26. COLLEGE/INSTITUTION

A. NAME

CITY

STATE

DATES ATTENDED (FROM MO/YR TO MO/YR)

DEGREE (IF ANY)

AREA OF STUDY

B. NAME

CITY

STATE

DATES ATTENDED (FROM MO/YR TO MO/YR)

DEGREE (IF ANY)

AREA OF STUDY

PERSONAL STATEMENT

27. Communicate your professional interests and achievements with regard to research experience and training, special projects, and professional accomplishments. Bibliographic references should be provided for all published papers. Describe future plans as defined by your specialty goal. You may also wish to describe your personal interests, activities, and circumstances. Any interruptions in your medical education should also be explained here. Use additional sheet, if necessary.

INTERVIEW SCHEDULING

THE FOLLOWING GENERAL TIME PERIOD IS MOST CONVENIENT FOR ME:

FROM _____ TO: _____

I AM ABLE TO SCHEDULE AN INTERVIEW ON THE FOLLOWING SPECIFIC DATE(S):

_____ (DATE) _____ (DATE) _____ (DATE) _____ (DATE)

I AM NOT ABLE TO COME FOR AN INTERVIEW

LETTERS OF REFERENCE, IN ADDITION TO THE DEAN'S LETTER, HAVE BEEN REQUESTED FROM THE FOLLOWING INDIVIDUALS

28. A. NAME AND TITLE

INSTITUTION

ADDRESS

29. B. NAME AND TITLE

INSTITUTION

ADDRESS

30. C. NAME AND TITLE

INSTITUTION

ADDRESS

31. CHECK ONE

I HEREBY WAIVE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS

I DESIRE ACCESS TO THE ABOVE LETTERS AND WILL SO INFORM THE AUTHORS

SIGNATURE AND DATE

32. I certify that the information submitted on these application materials is complete and correct to the best of my knowledge. I understand that any false or missing information may disqualify me for this position.

SIGNATURE OF APPLICANT : _____ DATE: _____