



AMERICAN PSYCHIATRIC ASSOCIATION
MINORITY MEDICAL STUDENT
ELECTIVE IN HIV PSYCHIATRY
APPLICATION FORM

Please complete this form and mail or fax to address on page 2.

BIOGRAPHICAL/PERSONAL INFORMATION

1. Name: _____

2. Home Address:

Phone: _____

3. Social Security No: _____

4. Email: _____ Year in Medical School _____

5. Sex: Male Female

6. U.S. Citizen: Yes No

If not a U.S. citizen, are you a permanent resident? Yes No

7. Ethnic Identification:

American Indian/Alaska Native _____

Asian American, including but not limited to: (check one)

Japanese

Indian

Chinese

Filipino

Korean

Pacific Islander

Other, please specify: _____

African-American (please self-define): _____

Hispanic, including but not limited to (check one):

Cuban

Mexican American

Puerto Rican

Other, please specify: _____

Other, please specify: _____

Medical Institution:

Name

Location

Dates

CURRICULUM VITAE

8. Send a copy of your updated curriculum vitae along with this application.

STATEMENT OF INTEREST

9. On a separate sheet, write a brief statement of interest, not to exceed one typewritten page.

I certify that the above information is correct.

Signature: _____

Date: _____

PLEASE NOTE: YOUR APPLICATION WILL NOT BE CONSIDERED UNLESS THE APPLICATION FORM HAS BEEN COMPLETED AND WE HAVE RECEIVED YOUR CURRICULUM VITAE, STATEMENT OF INTEREST, AND DEAN'S LETTER.

ALL MATERIAL MUST BE RECEIVED BY:
March 31, 2009

Send material to:

Office of HIV Psychiatry
American Psychiatric Association
1000 Wilson Blvd.
Suite 1825
Arlington, VA 22209
Tel: (703) 907-8668 or 1-888-357-7849
Fax: (703) 907-1089
Email: dpennesi@psych.org