Keane OpenNotes Fellowship in Patient Engagement and Transparency

Research Fellowship Program

Beth Israel Deaconess Medical Center

Beth Israel Deaconess Medical Center | HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

ELIGIBILITY AND APPLICATION:

We invite a broad range of postdoctoral candidates to apply to the Keane OpenNotes Fellowship in Patient Engagement and Transparency. Applicants are screened on the basis of their career goals and on the recommendations of faculty from their medical schools, residency programs, and doctoral programs. Applicants must be a U.S. Citizen or Permanent Resident.

- Ph.D. and other doctoral degrees: Please apply if you have interests in research that are aligned with the priorities of the fellowship program.

- M.D. applicants: You must be board-eligible or board-certified in internal medicine or another specialty at the start of their 1st fellowship year to be eligible. Foreign Medical School graduates must be certified by the Educational Council for Foreign Medical Graduates.

Each applicant must complete an **application form (including two statements), provide an updated CV/Resume and have three letters of recommendation** submitted by faculty who are familiar with the applicant's qualifications. If the applicant is an M.D., one of these letters must be from the Director of the current or most recent clinical training program.

The fellowship year begins on July 1. Personal interviews for those selected from the pool of applicants are generally held between mid-November and early-December. Notification of acceptance usually occurs by the end of January.

Candidates who apply to the fellowship have the opportunity to learn about program components during the interview process. Beth Israel Deaconess Medical Center is the primary institution for this fellowship and as such the site for the fellow's research activities, clinical practice (if applicable) and teaching activities.

Fellows applying to this program are required to complete a formal application to the Harvard T.H. Chan School of Public Health prior to beginning the fellowship. In addition to the fellowship stipend, the program pays full tuition for the HSPH Program in Clinical Effectiveness core curriculum. The application deadline for the 2020 Program in Clinical Effectiveness is **February 1**. For some fellows, all the courses that are required (45 credits) for a Master's level degree may be covered and the application deadline is earlier, on **December 1**.

APPLICANTS from UNDERREPRESENTED BACKGROUNDS:

BIDMC and OpenNotes are equal opportunity institutions and value the perspectives and experiences of students from underrepresented backgrounds. The program encourages underrepresented candidates to apply.

Questions, Applications, CVs, and Letters of Recommendation should be sent via email to:

Paola Miralles | Administrative Director
OpenNotes | Beth Israel Deaconess Medical Center
133 Brookline Avenue, Suite 2203 | Boston, MA 02215

Attn: Keane OpenNotes Fellowship
e-mail: pmiralle@bidmc.harvard.edu

Note: You must rename this PDF for it to save.

Beth Israel Deaconess Medical Center
Keane OpenNotes Fellowship in Patient Engagement and Transparency
(Fellowship Beginning July 1, 2020)

APPLICATION FORM

Section 1: PERSONAL DATA

1. Last Name: _____

   First Name: _____

   Middle Name: _____

2. Mailing address: _____

3. Best telephone number to reach you: _____

4. Email: _____

5. In case of emergency, notify (name and number): _____

6. Last 4 digits of Social Security Number: _____

7. Date of birth:(MM-DD-YYYY): _____

8. Are you a citizen of the United States or a Permanent Resident (Form I-551)?

   Yes ☐
   No ☐

9. If you are a graduate of a foreign medical school (except Canada), you are required to be certified by the Educational Council for Foreign Medical Graduates. If you are certified, please indicate below:

   Standard Certificate Number: _____

Date of passing ECFMG exam: _____

A copy of your certificate must be sent as a PDF file with your application to pmiralle@bidmc.harvard.edu.

Section 2: EDUCATION

10. College1: _____

    City1: _____

    Graduation Date1: _____

    Degree1: _____

    Minor1 (if applicable): _____

11. College2: _____

    City2: _____

    Graduation Date2: _____

    Degree2: _____

    Minor2 (if applicable): _____

12. Postgraduate Certificate:

    School: _____

    City: _____

    Certificate Date: _____

13. Graduate School: _____

    City: _____

    Graduation Date: _____

    Degree/Department: _____

    Thesis: _____

    First Postdoctoral: _____

    Second Postdoctoral: _____

14. Medical School: _____

    City: _____

    Graduation Date: _____

    Honors: ☐ ☐

NOTE: If you hold a graduate degree other than an MD, please skip Section 3 below and continue to Section 4.

Section 3: GRADUATE MEDICAL EDUCATION, LICENSURE, EXPERIENCE

15. Internship Training:

    Hospital: _____

    Location: _____

    Date: _____

Type: _____

16. Residency Training:

    Hospital: _____

    Location: _____

    Date: _____

    Type: _____

17. Fellowship Training:

    Hospital: _____

    Location: _____

    Date: _____

    Type: _____

    Subspecialty Board Certification: _____

18. 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?

    Yes ☐

    No ☐

    If yes, please give full details on a separate sheet.

19. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?

Yes ☐

No ☐

If yes, please give full details on a separate sheet.

20. Have you ever voluntarily relinquished your license?

Yes ☐

No ☐

If yes, please give full details on a separate sheet.

21. National and state board examinations (USMLE or equivalent):

Date: _____

State: _____

Number: _____

Pass ☐ Fail ☐

Date: _____

State: _____

Number: _____

Pass ☐ Fail ☐

Section 4: RESEARCH and CAREER PLANS

22. Do you plan to pursue a subspecialty fellowship in the future?

Yes ☐

No ☐

Please specify _____

23. Do you plan to earn any further degrees in the future?

Yes ☐

No ☐

Please specify _____

24. Personal Statement: Please submit a page-long personal statement (500 words) where you discuss the following: 1) what led you to apply to our fellowship; 2) your long-term goals; 3) the position you envision upon completion of this fellowship program; and 4) any additional information that may be helpful to the Selection Committee.

25. Research Statement: Please submit a page-long research statement (500 words) where you discuss the following: 1) your research interests in patient engagement and transparency; 2) potential research questions you are interested in exploring through this fellowship; and 3) why you may want to pursue an MPH.

26. While your CV will list your abstracts and publications, here please indicate two which best represent your work.

_____

_____

27. Please tell us how you heard about the fellowship program (check all that applies):

☐ Internet search

☐ Advisor / Mentor (please specify) _____

☐ Friend / Associate (please specify) _____

☐ Other (please specify) _____

Section 5: REFERENCES

Please arrange to have three letters of reference submitted. One must be from the Director of your current or most recent clinical training program, if applicable. List the three individuals from whom we can expect to receive letters of reference on your behalf:

Name1: _____

Institution1: _____

Email Address1: _____

Title1: _____

Name2: _____

Institution2: _____

Email Address2: _____

Title2: _____

Name3: _____

Institution3: _____

Email Address3: _____

Title3: _____

Section 6: ATTESTATION

I certify that, to the best of my knowledge and belief, all of my statements are true, correct, complete, and made in good faith. Entering your name and date will serve as your signature.

Candidate Name: _____ Date: _____

Please continue to the next page if you wish to voluntarily self-identify.

SELF-IDENTIFICATION FORMS

Beth Israel Deaconess Medical Center (the Medical Center) is an equal opportunity employer and does not discriminate against applicants for employment or employees on the basis of race, color, religion, sex or sexual orientation, national origin, age, disability, genetics, veteran status, military status or any other class protected by law.

As a federal contractor, the Medical Center also is committed to take affirmative action to employ and advance in employment of women, minorities, veterans of the Vietnam Era, qualified disabled veterans, other eligible veterans and disabled individuals. If you are a woman, minority, veteran or disabled individual, you may wish to be considered under these affirmative action programs. You are invited to provide this information on a voluntary basis, and your decision to not to provide will not result in adverse treatment. You may inform the Medical Center of your desire to benefit under its affirmative action programs at this time or any time in the future. The information you provide will only be used consistent with the law. Your answers to the questions will be kept confidential, but may be provided to supervisors who may be informed regarding any restrictions on work or duties of disabled individuals or necessary accommodations. In addition, this information may be provided to government officials monitoring the Medical Center's Affirmative Action Programs or to medical personnel such as first aid or safety staff if the nature of your condition may require medical treatment.

The Medical Center's affirmative action programs are available for inspection upon request in the Human Resources Department. If you are a woman, minority, eligible veteran or disabled individual, the Medical Center would like include you in its affirmative action programs. If you would like to be included please self-identify below:

Self-Identification for Ethnicity, Race, and Gender

Do you self-identify as Hispanic/Latino?

☐ Yes (A person of Cuban, Chicano, Mexican, Mexican American, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

☐ No

In addition, please select one or more of the following racial categories to describe yourself, if applicable:

☐ American Indian or Alaskan Native (A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliation or community attachment).

☐ Asian, not underrepresented (A person having origins in any of the any of the Asian subpopulations not considered underrepresented in the health professions include Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai)

☐ Asian, underrepresented (A person having origins in any of the Asian subpopulations considered underrepresented in the health professions include any Asian other than those stated above, i.e., Cambodian, Vietnamese, Malaysian)

☐ Black or African-American (A person having origins in any of the black racial groups of Africa)

☐ Native Hawaiian or Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)

☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa)

Do you identify as:

☐ Female

☐ Male

☐ I do not wish to self-identify

Do you identify as a sexual or gender minority (i.e., lesbian, gay, bisexual, or transgender)?

☐ Yes

☐ No

Self-Identification for Veteran Status

Again, we offer you the opportunity to complete this self-identification form. Submission of this information is voluntary and disclosing or declining to provide it will not subject you to adverse treatment. The information will be used in a manner consistent with federal and state laws.

Please voluntarily indicate if you are a:

☐ Disabled Veteran: Veteran of the U.S. military who is entitled to compensation (or who but for receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veteran Affairs, or a person who was discharged or released from active duty because of service-connected disability

☐ Recently Separated Veteran: Any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military

☐ Armed Forces Service Medal Veteran: Veteran who, while serving on active duty in the U.S. military, participated in a U.S. military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985

☐ Other Protected Veteran: Veteran who served on active duty in the U.S. military during a war or in a campaign or expedition for which a campaign badge has been authorized under laws administered by the Department of Defense

☐ Not a Veteran: None of the above apply

☐ I choose not to self-identify at this time

Self-Identification for Persons with Disabilities

In accordance with Sections 503 and 504 of the Rehabilitation Act of 1973, the provision of this information is on a voluntary basis and will be maintained in a separate location for affirmative action program use and will not be included in the personnel file of any employee for employment.

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

• Blindness • Deafness • Cancer • Diabetes • Epilepsy	• Autism • Cerebral palsy • HIV/AIDS • Schizophrenia • Muscular dystrophy	• Bipolar disorder • Major depression • Multiple sclerosis (MS) • Missing limbs or partially missing limbs • Post-traumatic stress disorder (PTSD)	• Obsessive compulsive disorder • Impairments requiring the use of a wheelchair • Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ Yes, I have a disability (or previously had a disability)
☐ No, I do not have a disability
☐ I do not wish to answer

Self-Identification for Persons from Disadvantaged Backgrounds

Please let us know if you meet the federal definitions for coming from "disadvantaged backgrounds" or "medically underserved communities." The provision of this information is voluntary and will not be included in the personnel file of any employee for employment.

The definition of "Disadvantaged" is that which is currently in use for health professions programs (42 CFR 57.1804 (c)) and includes both economic and educational factors that are barriers to an individual's participation in a health professions program. This means an individual who:

a) is from an environment that has inhibited the individual from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school, or from a program providing education or training in an allied health profession; or

b) is from a family with an annual income below a level based on low-income thresholds

according to family size, published by the U.S. Bureau of the Census, and adjusted annually for changes in the Consumer Price Index, and by the Secretary for use in health professions programs.

"Medically Underserved community" means an urban or rural population without adequate health care services. If you are unsure about whether your community qualifies, we can use the following geographic information to make that determination:

State:

County:

City/Town:

Please indicate if you believe you are from a:

Disadvantaged Background:

☐ Yes
☐ No
☐ Unsure

Medically Underserved Community:

☐ Yes
☐ No
☐ Unsure

Rural Residential Background:

☐ Yes
☐ No
☐ Unsure

Please use the following link for guidance about rural residential background https://datawarehouse.hrsa.gov/tools/analyzers/geo/Rural.aspx