APPLICATION COVER SHEET

Electronic applications must be submitted in one email no later than 5:00 pm Eastern Time on Friday, January 18, 2019 to:

Carol A. Hughes
Operations Director
Shapiro Institute for Education and Research
617-667-5494
cahughes@bidmc.harvard.edu

Your complete electronic application (submitted as one PDF) must include the following elements:

I. APPLICATION COVER SHEET (downloadable: www.bidmc.org/medicaleducation)
II. LETTER OF INTEREST (no longer than two pages)
III. LETTER OF SUPPORT FROM THE DEAN OF YOUR MEDICAL SCHOOL OR ASSOCIATE DEAN FOR GME
IV. BIOGRAPHICAL SKETCHES OF TEAM MEMBERS (no longer than 1 page for each member)

Please contact the Shapiro Institute for Education and Research by phone at (617) 667-5494 if you have questions or need any clarification.

Please fill in the requested information in the allotted spaces.

Medical School

Affiliated Hospital/Medical Center

Names of Participants (more detailed information required on attached pages):

Leader with oversight for undergraduate medical education curriculum

Pre-clerkship or clerkship course director

Leader within graduate medical education

Core residency program director

Other team member (optional)
PARTICIPANT INFORMATION

1. 
   Last name ________________________________  First name ________________________________  M.I. ________________________________  Degree ________________________________
   Academic title ________________________________
   Educational role(s) ________________________________
   Clinical discipline ________________________________
   Mailing Address ________________________________
   Telephone ________________________________  FAX ________________________________
   E-mail ________________________________

2. 
   Last name ________________________________  First name ________________________________  M.I. ________________________________  Degree ________________________________
   Academic title ________________________________
   Educational role(s) ________________________________
   Clinical discipline ________________________________
   Mailing Address ________________________________
   Telephone ________________________________  FAX ________________________________
   E-mail ________________________________

3. 
   Last name ________________________________  First name ________________________________  M.I. ________________________________  Degree ________________________________
   Academic title ________________________________
   Educational role(s) ________________________________
   Clinical discipline ________________________________
   Mailing Address ________________________________
   Telephone ________________________________  FAX ________________________________
   E-mail ________________________________
Team leader and primary contact person (should be one of the team members listed above)