Training
In
Clinical
Research

UCSF

Instructions for Completing the Application Form for the

Advanced Training in Clinical Research (ATCR) Certificate Program

- PLEASE COPY AND SAVE THE APPLICATION FORM ON YOUR COMPUTER BEFORE COMPLETING IT.
- BEGIN TYPING IN THE FIRST SHADED BOX.
- USE THE **TAB KEY** (***NOT*** *THE ENTER OR RETURN KEY*) TO MOVE TO THE NEXT SHADED BOX.
- YOU MAY ALSO USE THE **MOUSE** TO MOVE TO ANY SHADED BOX AT ANY POINT.
- USE THE MOUSE TO CLICK ON THE CHECK-BOXES.

Application Check List

- ❑ Application Form for Advanced Training in Clinical Research (ATCR) Certificate Program
  (Submit to Olivia De Leon at the address below. Please also email to olivia@epi.ucsf.edu)
- ❑ One letter of recommendation
  (Reference must send the letter of recommendation directly to our program)
- ❑ For applications to the ATCR Credit-Bearing Program: Official transcripts from all institutions beyond high school (Submit in sealed envelope with official seal of the institution directly to Olivia De Leon at the address below); if you are currently in school, please be sure to also send current transcript.
- ❑ For applications to the ATCR Traditional Program: Follow same instructions as for Credit-Bearing Program except that official transcripts are NOT required for applicants who have previously completed doctoral level training (defined as medical, dental, or pharmacy school or PhD-level training).

Send materials to:
Olivia De Leon
Training in Clinical Research (TICR) Program
University of California, San Francisco
Department of Epidemiology and Biostatistics
Mission Hall (UCSF Box 0560)
550 16th Street, 2nd floor
San Francisco, CA 94143
(For FedEx only, use 94158)

Contact phone/fax:
415-514-8231 (telephone)
415-514-8150 (fax)

For Administrative Use Only:
Date Received: Reference received: Application Complete:
Professional school transcript (if pre-doctoral student):

vs. April 11, 2016

Training In Clinical Research

Application Form

Advanced Training in Clinical Research (ATCR) Certificate Program

UCSF

Current Information:

_____ ☐ Male ☐ Female / /
Last Name *First Name* *Middle Initial* *Sex (check)* *Date of Birth*

_____ ( ) -
Home Address *City* *State* *Zip Code* *Telephone Number*

_____
Office Address *City* *State* *Zip Code*

_____ ( ) - _____ ( ) -
UCSF Box # *Electronic Mail Address* *Office Telephone Number* *Ext.* *Fax Number*

_____
Current Position/Title (e.g., Fellow) *Institution* *School (e.g., Medicine, Dentistry, Pharmacy, Nursing)*

_____
Department *Division (if applicable)* *Degree (e.g., MD)* *Country of Citizenship*

Race/Ethnicity:

☐ Puerto Rican
☐ Chicano/Mexican American
☐ Latino/Latin American
☐ American Indian/Native American
☐ White/Caucasian
☐ East Indian/Pakistani
☐ Polynesian/Pacific Islander
☐ African/African American
☐ Filipino/Filipino American
☐ Chinese/Chinese American
☐ Japanese/Japanese American
☐ Korean/Korean American
☐ Thai/Other Asian
☐ Vietnamese/Vietnamese American
☐ Other (please specify): _____

Information Pertaining to the Time of Desired Date of Enrollment:
Leave blank if you will be only affiliated with the ATCR Program and not any other program at UCSF or other institution.

_____
Your Anticipated Position (e.g., Fellow) *Anticipated Institution* *Anticipated School (e.g., Medicine, Dentistry)*

_____
Anticipated Department *Anticipated Division (if applicable)*

_____
Anticipated Fellowship Director (if a Fellow) *Anticipated Department Chair* *Anticipated Division Chief (if applicable)*

Research Mentors During the ATCR Program:

Leave blank if you are originating from outside UCSF and are in the process of identifying a mentor.

_____
Anticipated Research Mentor #1 *Mentor #1's Institution* *Mentor #1's School*

_____
Mentor #1's Department *Mentor #1's Division (if applicable)*

_____
Anticipated Research Mentor #2 *Mentor #2's Institution* *Mentor #2's School*

_____
Mentor #2's Department *Mentor #2's Division (if applicable)*

Education: ***list all undergraduate, graduate, and professional schools attended in chronological order.***

1. _____
Institution *Location*

_____
Dates of Attendance *Major* *Degree and Graduation Date*

2. _____
Institution *Location*

_____
Dates of Attendance *Major* *Degree and Graduation Date*

3. _____
Institution *Location*

_____
Dates of Attendance *Major* *Degree and Graduation Date*

4. _____
Institution *Location*

_____
Dates of Attendance *Major* *Degree and Graduation Date*

5. *Institution* *Location*

_____
Dates of Attendance *Major* *Degree and Graduation Date*

Post Graduate Training: ***include internships, residencies, fellowships, and other appointments.***

1. _____
Position *Institution* *School (e.g., Medicine, Dentistry)*

_____
Department *Division* *Location* *Dates of Attendance*

2. _____
Position *Institution* *School (e.g., Medicine, Dentistry)*

_____
Department *Division* *Location* *Dates of Attendance*

3. _____
Position *Institution* *School (e.g., Medicine, Dentistry)*

_____
Department *Division* *Location* *Dates of Attendance*

4. _____
Position *Institution* *School (e.g., Medicine, Dentistry)*

_____
Department *Division* *Location* *Dates of Attendance*

Academic Honors, Honorary Societies, and Awards:

_____
Date *Title*

_____
Date *Title*

_____
Date *Title*

_____
Date *Title*

Research Experience: ***include major clinical and laboratory research experiences (full and part-time).***

1. _____
Position/Appointment *Institution*

_____
Project Title *Dates*

2. _____
Position/Appointment *Institution*

_____
Project Title *Dates*

3. _____
Position/Appointment *Institution*

_____
Project Title *Dates*

4. _____
Position/Appointment *Institution*

_____
Project Title *Dates*

5. _____
Position/Appointment *Institution*

_____
Project Title *Dates*

Board Certification Status: *include Specialties (e.g., Internal Medicine, Pediatrics) and Sub-Specialties (e.g., Infection Diseases, Cardiology)*

Are you board certified or eligible? YES ☐ NO ☐

If yes, specify the board(s) *1)* _____
2) _____

1) *Have you taken the exam?* YES ☐ NO ☐
Status: ☐ *exam taken, awaiting report* ☐ *failed exam* ☐ *board certified - date:* / /

2) *Have you taken the exam?* YES ☐ NO ☐
Status: ☐ *exam taken, awaiting report* ☐ *failed exam* ☐ *board certified - date:* / /

Publications:

Use the provided optional additional information page if publications exceed one page.

Objectives:

Please describe your reasons for interest in the program. Include your objectives, clinical and research interests and goals, and how acceptance into the program can help you accomplish these. Please limit your response to this page.

Optional Additional Information:

Please use the following space to tell us anything else you would like us to know about your background, experience, or objectives. Please limit to one page.

Letter of Reference:

Please ask your Division Chief/Department Chair (if you are a faculty member), Program Director (if you are a Resident, Fellow or a pre-doctoral student in a research fellowship), or Faculty Advisor (if you are pre-doctoral outside of a fellowship or a graduate student) to send our program a concise letter describing (a) your qualifications, (b) your approximate rank among peers, (c) your availability all day on Tuesdays and Thursdays from mid-September to May for classroom work, and (d) your availability for spending at least 70% of effort devoted to clinical research activities in your home department and in our program. If you are otherwise unaffiliated with UCSF, please obtain this letter from a current or recent instructor, advisor, or supervisor. We define recent as the past two years.

_____

Name of Reference Person

_____

Address

_____

Address

Waiver:

☐ I waive the right to read this letter at a later time. ☐ I do not waive the right to read this letter.

- -

Social Security Number: Include this ONLY on the hard copy of the application that you sign

Signatures:

If selected as a Scholar in the Advanced Training in Clinical Research (ATCR) Program, the applicant will complete the core curriculum and its assignments, and spend at least 70% time from September to June in activities related to clinical research in the applicant's home department and in the ATCR program.

_____	_____	_____
(Applicant's Signature)	*Research Mentor Name* *(Leave blank if you are originating from outside UCSF and are in the process of identifying a mentor)*	*Research Mentor Signature*

For applicants affiliated with UCSF only:

_____	***or***	_____	***or***	_____
(Program Director Name)		(Division/Department, Chief Name)		(Faculty Advisor Name)
_____	***or***	_____	***or***	_____
(Program Director signature)		(Division/Department, Chief signature)		(Faculty Advisor signature)

Date of Application: / /

Mark which of 2 tracks you are applying for: ☐ Traditional ATCR Program

☐ Credit-bearing ATCR Program (This program also requires a separate application to the UCSF Graduate Division)

Please remember to submit all applicable official school transcripts.

Send materials to:
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University of California, San Francisco
Department of Epidemiology and Biostatistics
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Please also send a copy of this application form, as an email attachment, to olivia@epi.ucsf.edu