Harold Amos Medical Faculty Development Program (AMFDP)

Eligibility Criteria *

* Indicates required

Eligibility Criteria

To be eligible to submit an application, candidates must be physicians who:

- are from historically disadvantaged backgrounds (ethnic, financial or educational);
- are citizens or permanent residents of the United States or its territories at the time of application; and
- are now completing or have completed their formal clinical training. (Preference will be given to physicians who have recently completed their formal clinical training.)

Finalists will be selected from among those submitting applications. Finalists will be requested to submit Finalist Documentation, which must be submitted by a university, school of medicine or research institution that is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code with which the prospective scholar will be affiliated during the term of the fellowship.

1. Do you fit the eligibility criteria described above? *

◯ Yes
◯ No

A recipient cannot be related to any Officer** or Trustee of the Robert Wood Johnson Foundation, or be a descendent of the Foundation's founder.

- Are you related by blood or marriage to any Officer or Trustee of the Robert Wood Johnson Foundation?
- Are you a descendant of General Robert Wood Johnson? *

***The Officers are the Chairman of the Board of Trustees; President and CEO; Chief of Staff; General Counsel; Secretary; and Assistant Secretary of the Foundation.*

2. Do either of the above apply to you? *

◯ Yes
◯ No

3. If you specified "Yes" in the question above, please indicate the name(s) of the person/people to whom you are related. Include their role (e.g. Chairman, Chief of Staff, founder). *

You may skip this question if you respond "No" to the questions above.

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Key Contact Information *

* Indicates required

- Please enter the contact information needed for the AMFDP applicant, mentor, co-mentor (if applicable) and the AMFDP applicant's home contact information. Please complete all required contacts.
- To save your partially completed page, scroll to the bottom of this page and select "Save, continue editing" or "Save, return home".
- Use the "Copy feature" to copy completed organizational and address information to a new contact. Choose a role from the drop-down menu and then select the "Copy" button.

AMFDP Applicant *

Enter the name and contact information of the AMFDP Applicant below. This is a required entry.

E-mail *

Confirm E-mail *

First Name *

Middle Name or Initial

Last Name *

Applicant's Organization *

Position *

Department

Business Unit

Address *

Address (line 2)

City *

State / Territory *

Zip / Postal Code *

Office Phone Number * Phone Ext.

Cell Number

Fax Number

Mentor *

Enter the name and contact information of the Mentor below. This is a required entry.

E-mail *

Confirm E-mail *

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First Name*

Middle Name or Initial

Last Name*

Organization*

Position*

Department

Business Unit

Address*

Address (line 2)

City*

State / Territory*

Zip / Postal Code*

Office Phone Number*

Phone Ext.

Cell Number

Fax Number

Co-Mentor

Enter the name and contact information of the Co-Mentor below (if applicable).

E-mail*

Confirm E-mail*

First Name*

Middle Name or Initial

Last Name*

Organization*

Position*

Department

Business Unit

Address*

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Address (line 2)

City *

State / Territory *

Zip / Postal Code *

Office Phone Number *

Phone Ext.

Cell Number

Fax Number

Applicant's Home Contact Information *

Enter applicant's home contact information below.

Alternate E-mail

Confirm Alternate E-mail

Address *

Address (line 2)

City *

State / Territory *

Zip / Postal Code *

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Contact Information for References *

* Indicates required

- Enter contact information for three people writing your letters of reference. An optional fourth reference may also be entered.
- To save your partially completed page, scroll to the bottom of this page and select "Save, continue editing" or "Save, return home".
- Use the "Copy feature" to copy completed organizational and address information to a new contact, choose a role from the drop-down menu and selecting the "Copy" button.

Reference #1 *

Please complete the contact information for this reference. This is a required entry.

E-mail *

Confirm E-mail *

First Name *

Middle Name or Initial

Last Name *

Organization *

Position *

Department

Business Unit

Address *

Address (line 2)

City *

Country

State / Territory *

Zip / Postal Code *

Office Phone Number *

Phone Ext.

Cell Number

Fax Number

Reference #2 *

Please complete the contact information for this reference. This is a required entry.

E-mail *

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Confirm E-mail *

First Name *

Middle Name or Initial

Last Name *

Organization *

Position *

Department

Business Unit

Address *

Address (line 2)

City *

Country

State / Territory *

Zip / Postal Code *

Office Phone Number * Phone Ext.

Cell Number

Fax Number

Reference #3 *

Please complete the contact information for this reference. This is a required entry.

E-mail *

Confirm E-mail *

First Name *

Middle Name or Initial

Last Name *

Organization *

Position *

Department

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Business Unit

Address *

Address (line 2)

City *

Country

State / Territory *

Zip / Postal Code *

Office Phone Number *

Phone Ext.

Cell Number

Fax Number

Reference #4

Please complete the contact information for this reference (if applicable).

E-mail *

Confirm E-mail *

First Name *

Middle Name or Initial

Last Name *

Organization *

Position *

Department

Business Unit

Address *

Address (line 2)

City *

Country

State / Territory *

Zip / Postal Code *

Office Phone Number *

Phone Ext.

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Cell Number	
Fax Number	

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Project Information Questions *

* Indicates required

Please respond to the following questions.

1. What is your anticipated start date in the program? *

   ◯ January 1, 2012 ◯ July 1, 2012

2. Please indicate your country of citizenship. *

3. Please specify your historically disadvantaged ethnic background. *

   Select all that apply.

   - [ ] African American
   - [ ] Mexican American
   - [ ] Mainland Puerto Rican
   - [ ] Native American
   - [ ] Other (specify below)

4. Please specify your historically disadvantaged educational background. *

   Select all that apply, or select "None of the above" if not applicable.

   - [ ] Poorly-rated school system
   - [ ] Learning disability
   - [ ] None of the above
   - [ ] Other (please specify below)

5. Please specify your historically disadvantaged financial background. *

   Select all that apply, or select "None of the above" if not applicable.

   - [ ] Urban poverty
   - [ ] Rural poverty
   - [ ] Lack of health insurance
   - [ ] None of the above
   - [ ] Other (please specify below)

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6. What is your current position? *

- ◯ Assistant Professor
- ◯ Instructor
- ◯ Fellow
- ◯ Resident
- ◯ Staff Physician
- ◯ Researcher
- ◯ RWJF Clinical Scholar
- ◯ Other (please specify in text box below)

7. What is the name of your current institution? *

8. Is your current institution (which you listed in the question above) the one at which the award would be activated? *

If your response is "Yes" you will skip the next question.

◯ Yes ◯ No

9. Specify the institution at which you intend to activate the award. *

10. What is your research area? *

You may choose more than one response.

☐ Basic/biomedical research ☐ Clinical research ☐ Health services research/epidemiology

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11. What is your medical specialty (for example, pediatrics, cardiology, internal medicine)? *

12. What is your secondary medical specialty or subspecialty (for example, pediatric oncology or outcomes research)?

If not applicable, you may skip this question.

13. What is your mentor's area of research interest? *

14. What is your co-mentor's area of research interest?

If you have only one mentor (as most applicants do), you may skip this question.

15. Have you applied to the program or its predecessor, the Minority Medical Faculty Development Program, in the past? *

If you respond "No," you will skip the next question.

◯ Yes ◯ No

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16. Because you responded "Yes" to the above question, please indicate the years in which you applied. *

Select all that apply.

- [ ] 1999
- [ ] 2000
- [ ] 2001
- [ ] 2002
- [ ] 2003
- [ ] 2004
- [ ] 2005
- [ ] 2006
- [ ] 2007
- [ ] 2008
- [ ] 2009
- [ ] 2010

17. Are you applying as part of the ASH-AMFDP partnership? *

This is a partnership between the American Society of Hematology and the Harold Amos Medical Faculty Development Program.

◯ Yes ◯ No

18. Have you applied to, are you in the process of applying to, or do you intend to apply to another Robert Wood Johnson Foundation program? *

If you respond "No," you will skip the next question.

◯ Yes ◯ No

19. Because you responded "Yes" to the above question, please provide the names of the programs to which you have applied or intend to apply, including the month/year of application in the text box below. *

Please use the format (program name, month/year of application).

20. Please give us the name of the high school from which you graduated and its location (city and state). *

Your response should be in the following format (ABC High School, Atlanta, GA).

21. Which medical school did you attend? *

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22. What was your year of graduation from medical school? *

23. Where did you complete your residency? *

24. Do you have an M.P.H., Ph.D., or other advanced degree in science or health care?

Choose from the selections below, and if applicable, specify in the text box below.

- [ ] M.P.H.
- [ ] Ph.D.
- [ ] Other - Specify your advanced degree in science or health care below.

25. Occasionally, we are asked to provide contact information for applicants or awardees to other Robert Wood Johnson Foundation programs, or other organizations which share similar goals or programs that have funding opportunities available. We never release information without consent.

Do you consent to having your name, business contact information, and other information (for example, specialty or institution) released? *

◯ Yes ◯ No

26. How did you find out about the AMFDP (or its precursor, the Minority Medical Faculty Development Program)? *

27. Please use this space if you wish to make any comments about your application or the application process.

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Your comments are optional.

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Executive Summary *

* Indicates required

Below you will enter your project title and a 1500-character summary of the problem you propose to address.

Project Title *

Executive Summary *

Provide a brief description of the problem you propose to address. Your description must be limited to 1500 characters (including spaces). Samples of executive summaries are available in the How to Apply section of the Applicant Guide (see link on left side of screen).

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Proposal & Supporting Documents *

* Indicates required

Proposal and supporting documents below must be submitted. Some will be uploaded, and others will be mailed separately. For additional information on mail-in documents, refer to the "How to Apply: A Step-by-Step Guide" located in the Applicant Guide (link on left side of screen). Refer to the document name in the "Templates" column below for specific instructions.

When you have completed this page, select the "Save, section finished" button at the bottom of the page. Once all sections of your application are complete, you may "Submit" your proposal from the Home Page. All uploaded documents may be updated and replaced until you submit your application.

Description	Templates	Uploaded Documents
Proposal * Download the template and use it to guide your detailed description of the project being proposed.	Proposal	
Applicant CV * Complete the applicant CV template to provide us with information about your education and professional experience. You may format your CV in any way you want. Details about what must be included can be found on the template.	Applicant CV	
Mentor CV * Complete the mentor CV template provided. We prefer a National Institutes of Health biosketch; however, you may format the CV in any way you want. If you have more than one mentor, you must upload a CV for each mentor.	Mentor CV Template	
Mentor Statement * Use the mentor statement template provided to upload your mentor statement detailing background, institutional resources and support for your project. If you have more than one mentor, you may upload a mentor statement for each mentor.	Mentor Statement	
References/Citations * Complete the references template provided to list references/citations for your scientific proposal.	References Template	
Supplemental Documents Most applicants will not have supplemental documents. For examples of what to include as a supplemental document, please see the instructions on the template.	Supplemental Documents	
Letter to Proposed Mentor This letter should be sent to your proposed mentor. The information received from the mentor should be uploaded to this application system using the "Mentor Statement" template above.	Letter to Proposed Mentor	
Mail in only: 3 Confidential Reference Reports To ensure strict confidentiality, the completed forms should be mailed directly to the National Program Office postmarked no later than March 17, 2011. They should not be returned to the applicant. One of the referees must be someone familiar with your research interests and/or experience. Your proposed Mentor(s) should not be used as a reference. See the How to Apply: A Step-by-Step Guide for mailing instructions.	Confidential Reference Report	
Mail in only: Transcripts Please request that your undergraduate college(s), medical school(s), and any institution at which you undertook health-related coursework (toward an MPH or PhD, for example) forward your transcripts directly to the AMFDP National Program Office postmarked no later than March		

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17, 2011. See the How to Apply: A Step-by-Step Guide for mailing instructions.		

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Applicant's Name ____

Harold Amos Medical Faculty Development Program

CONFIDENTIAL REFERENCE REPORT

TO THE REFERENCE:

This applicant to the Harold Amos Medical Faculty Development Program has named you as one of three references. We ask your cooperation in responding as quickly as possible. Your reference must be postmarked no later than March 17, 2011. To maintain strict confidentiality, return the completed form directly to James R. Gavin III, M.D., Ph.D., Program Director, Harold Amos Medical Faculty Development Program, 714 N. Senate Avenue, EF 212, Indianapolis, IN 46202. Questions may be directed to Nina Ardery at 317-278-0500 or amfdp@indiana.edu.

Reference Name ______________________________________
Title ____
Institution ____
Telephone (_____) _____________________________________
E-mail ____

1. Please evaluate the applicant's performance using the scale below, and using this as the basis of your assessment in Section 3.
   0: Unable to judge   1: Poor   2: Fair   3: Excellent   4: Outstanding

Overall preparation for the Harold Amos Medical Faculty Development Program:

Industry/perseverance:

Motivation:

Initiative:

Ability to meet deadlines:

Maturity:

Clinical ability:

Interpersonal facility with peers:

Interpersonal facility with patients:

Demonstrated skill at research:

Potential skill at research:

Integrity:

Judgment/critical sense:

Intellectual ability:

Demonstrated originality:

Potential originality:

Leadership capacity:

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0: Unable to judge 1: Poor 2: Fair 3: Excellent 4: Outstanding

Demonstrated productivity:

Potential productivity:

Ability to communicate (written):

Ability to communicate (verbal):

Overall evaluation:

2. Please tell us how long you have known the applicant and in what capacity.

3. Please elaborate on the applicant's performance on the basis of which you arrived at your assessment in Section 1. If possible, please cite some specific illustration of the applicant's performance. Use additional pages if necessary.

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