



Space Medicine Fellowship Application

Thank you for your interest in the UCLA Space Medicine Fellowship. We look forward to reading your application! If you have any questions about our fellowship, feel free to email spacemed@mednet.ucla.edu to learn more.

Information About Applying

- Application Deadline: November 1
- Email To: spacemed@mednet.ucla.edu and include “Application” in the subject

Requirements to Apply

- Must be a graduate of a 4 year ACGME EM residency program (or equivalent)
- Must be eligible for a license in the State of California
- Must be eligible for ITAR (International Traffic in Arms Regulations) compliance

Application Documents

- Curriculum Vitae
 - Please include your legal name, email, home address, and phone number
- Letter of Interest (1-2 pages)
- Application Questionnaire Answers (1-2 pages total)
- 3 Letters of Recommendation
 - If graduating from residency please include one letter from your program director
- Current Medical License
- Disclosure Form (attached)

Application Questionnaire

1. What has been your inspiration to pursue a training pathway in Space Medicine?
2. What experiences have you had that are relatable to Space Medicine?
3. What skills do you possess outside of medicine?
4. What ultimate goal do you have that this fellowship may help you obtain?
5. Would you be willing to be embark on a long duration exploration mission during your lifetime?

Application Timeline

Application decisions will be made by December 1st. You should receive an email after this date and before the end of December. We thank you for your interest in the UCLA Space Medicine fellowship and are looking forward to reading your application!



Disclosure Form

1. Has your license, registration, certification, permit or authorization to practice your profession or occupation or to provide health care services of any nature (either as a student, intern, resident or in any other capacity) ever been (or is undergoing consideration of being) denied, restricted, suspended, not renewed, revoked, voluntarily or involuntarily relinquished or been (or is currently being) subject to investigation, review, reprimand, warning or any disciplinary action or probationary condition?

- Yes
- No

2. Have you ever been, or are you currently the subject of a disciplinary action or investigation by any government or private agency, court or peer review organization concerning your professional license or registration, certification, permit or authorization to provide health care services?*

- Yes
- No

3. Have you ever been denied clinical privileges, membership, participation, contractual affiliation and/or employment by any health care organization, including but not limited to, a hospital, medical/professional staff or HMO?*

- Yes
- No

4. Have your clinical privileges, membership, participation and/or employment in any health care organization ever been (or is currently being) investigated, restricted, reduced, suspended, terminated, revoked, involuntarily not renewed or subject to a warning or any disciplinary action or probationary condition?

- Yes
- No

5. Have you ever involuntarily or voluntarily under threat of investigation relinquished or withdrawn your request for clinical privileges, membership,

participation, contractual affiliation or employment with any hospital or other health care organization?

- Yes
- No

6. Have you ever been terminated from, denied participation in or asked to resign from any post graduate educational training program or professional educational experience, including any residency, internship, fellowship, externship, or clerkship for reasons related to your quality of care, clinical competence, professional conduct, ethics, or academic or clinical performance?

- Yes
- No

7. Have you ever been the subject of any disciplinary action including, but not limited to, probation, investigation, reprimand, restriction, suspension, warning or limitation during your enrollment or participation in any post graduate education training program or professional educational experience, including any internship, residency, clinical rotation, externship or fellowship?*

- Yes
- No

8. Have you ever been notified that a report, complaint or other filing regarding your practice, or a malpractice payment made on your behalf, has been or will be made to the National Practitioner Data Bank or any state licensing board?

- Yes
- No

9. Have you ever been convicted of, or plead guilty to, a felony criminal offense and/or placed on deferred adjudication or probation for a felony criminal offense?

- Yes
- No

10. Have you ever been convicted of a criminal offense related to the delivery of an item or service under Federal or State health care programs?*

Yes

No

11. Have you ever been convicted of a felony related to the neglect or abuse of patients in connection with the delivery of a health care item or service, related to health care fraud or related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

Yes

No

12. Have your fees, quality of care or other practices ever been subject to investigation or action, including fraud or abuse proceedings, by a government agency or third party payor, including but not limited to suspension, sanction or other restriction by any private, federal or state health care program, including Medicare or Medicaid?

Yes

No

13. Have you ever been sanctioned by and/or excluded from a federal or state health care program (e.g., Medicare or Medicaid)?

Yes

No

14. Have you filed paperwork with any medical program to formally "opt out" of a federal or state health care program, such as Medicare, within two (2) years of the date of this application?

Yes

No

15. Have you engaged in illegal drug use within one (1) year of the date of this application?

Yes

No

I hereby declare the answers to the above questions are accurate to the best of my knowledge.

Name

Date

Signature