

Department of Obstetrics and Gynecology

Women’s Mental Health Fellowship Application

Dear Applicant,

Thank you for your interest in the BCM Women’s Mental Health Fellowship. We look forward to reviewing your application. Please note that all application material, (including letters of recommendation) should be return no later than September 15, 2025.

**Fellowship Requirements:**

1. Applicants must have completed (or be in the final year of) a residency in Obstetrics and Gynecology or Psychiatry at an ACGME accredited institution.
2. Must be a US citizen or green card holder

**The following documents are *required* to support your fellowship application:**

1. A minimum of three letters of recommendation, o*ne letter must be from the Residency Program Director.*
2. Current curriculum vitae.
3. Copy of medical school diploma.
4. Personal statement of career goals, with discussion of how you plan to use this training.
5. Original or copy of USMLE transcript.
6. CREOG Score Report for all years of residency to date.

Application packets are acceptable and can be submitted directly via email to department of OB/GYN Education Office, Attn: Ivory McCarter ([ivory.mccarter@bcm.edu](mailto:ivory.mccarter@bcm.edu) ) or [obgyneducation@bcm.edu](mailto:obgyneducation@bcm.edu).

Thank you!

Osarumen Nicole Doghor, MD Michael A. Belfort, MD PhD, FRCSC, FRCOG

Director, Women’s Mental Health Fellowship Ernst W. Bertner Chairman and Professor Baylor Department of Obstetrics and Gynecology Department of Obstetrics and Gynecology

Professor, Departments of Surgery and Anesthesiology

Baylor College of Medicine

Obstetrician and Gynecologist-in-Chief

Texas Children's Hospital

  
 Department of Obstetrics and Gynecology

**Women’s Mental Health Fellowship Application**

**Applicant Information**

|  |  |  |
| --- | --- | --- |
| First Name | Last Name | Suffix (MD, DO, MPH) |
| Email Address | | Country of Citizenship |

**Contact Address**

|  |  |  |  |
| --- | --- | --- | --- |
| Street | | | |
| City | State/Providence | Zip/Postal Code | Country |
| Preferred Phone | Phone 2 (home) | Fax | |

**Permanent/Home Address**

|  |  |  |  |
| --- | --- | --- | --- |
| Street | | | |
| City | State/Providence | Zip/Postal Code | Country |

**EDUCATION AND TRAINING**

**Undergraduate Education**

Institution, City, State (or Country) Dates Attended Degree, Field of Study

|  |  |  |
| --- | --- | --- |
|  |  |  |
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**Medical School**

Institution, City, State (or Country) Dates Attended Degree, Field of Study

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**Internship/Residency/Fellowship**

Institution, City, State (or Country) Dates Attended Degree, Field of Study

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| --- | --- | --- |
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**Other Graduate Education**

Institution, City, State (or Country) Dates Attended Degree, Field of Study

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**LICENSING AND CERTIFICATION**

**USMLE Test** Results (3-digit score) Date(s)

|  |  |  |
| --- | --- | --- |
| Step 1 |  |  |
| Step 2/Step 2 CK |  |  |
| Step 2 CS (if taken) |  |  |
| Step 3 |  |  |

(Please include results for all attempted examinations)

**Medical Licenses**

Type Certificate Number Valid Dates Issuing State

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |

**Specialty Board Eligibility/Certification**

Are you board certified? Yes ☐ No ☐

Which American Board? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, when will you become board eligible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By my signature below, I certify that the information enclosed in this application is accurate:*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_/\_\_\_\_