THE CHILDREN'S HOSPITAL *of* PHILADELPHIA
34th Street and Civic Center Boulevard
Philadelphia, PA 19104-4399
Telephone 215-590-1000

FELLOWSHIP APPLICATION

Please attach recent photo **MUST BE INCLUDED to get an interivew**	**PLEASE DO NOT WRITE IN THIS SECTION** **Appointment as:**_____ _____ **From:**_____ **To:**_____

I hereby apply for appointment as a Graduate Medical Trainee at The Children's Hospital *of* Philadelphia for_____months, beginning_____ (with vacation, depending on length of service, being provided at a time convenient to the hospital).

PLEASE ✓ APPOINTMENT DESIRED

Pediatric Level -1	Dental Resident	Research Fellow
Pediatric Level -2	Surgical Resident	Observer/Visitor
Pediatric Level -3	Clinical Fellow	Other:_____

SPECIALTY _____

PLEASE TYPE OR PRINT

Full Name:_____M.D._____ M.B.B.S _____ .D.S._____
D.O._____ M.B.B.Ch. _____ D.M.D._____

Present Address:_____

City:_____State:_____Zip:_____Country:_____

Telephone:_____Beeper #: _____

E-Mail Address:_____Fax No.:_____

Permanent Address:_____

Place of Birth:_____Date of Birth:_____Married_____Single_____

Citizen of:_____ U.S. Social Security No.:_____

U.S. Unrestricted Medical License (attach copy):

State:_____No._____

State:_____No._____

Graduate Medical Training License (attach copy):

State:_____No:_____

State:_____No:_____

U.S. Licensing Exams passed (attach copy of scores for each exam):

MCCQE & LMCC_____FLEX_____FLEX 1_____FLEX II_____NBME 1_____NBME II_____NBME III_____
USMLE 1_____USMLE 2_____USMLE 3_____

INTERNATIONAL MEDICAL GRADUATES (attach copies of each document)

ECFMG Certificate No._____Type if Visa_____Hold_____Needed_____

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PREMEDICAL EDUCATION: Institution From To Degree

_____

_____

_____

MEDICAL EDUCATION: Institution From To Degree

_____

_____

_____

HOSPITAL TRAINING (do not list rotations in medical school):

Hospital Location From To Degree

_____

_____

_____

_____

_____

_____

POSTGRADUATE EDUCATION (organized courses only):

_____

_____

SPECIAL TRAINING (not already listed, such as assistantships, practice, etc.)

_____

_____

_____

_____

_____

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BOARD CERTIFICATION

Year Specialty Name of Board Country of Issuing Board

_____

_____

ADDITIONAL INFORMATION (such as publications, summer work, extra curricular activities):

_____

_____

_____

_____

_____

_____

_____

_____

REFERENCES: Communications concerning professional ability and personal qualifications must be sent under Separate cover directly to _____ The Division of _____ at The Children's Hospital *of* Philadelphia from at least three physicians, preferably under whom you have served or trained. **Letters of recommendation must be requested by the applicant**. List references below:

_____

_____

_____

_____

_____

_____

SIGNATURE OF APPLICANT:_____DATE:_____

Return to: psychiatrytraining@chop.edu