THE CHILDREN'S HOSPITAL *of* PHILADELPHIA
3401 Civic Center Boulevard, Philadelphia, PA 19104-4399

CHOP Common Graduate Medical Education Application Form

Attach recent photo (optional)

I hereby apply for appointment as a Graduate Medical Trainee as follows:

Program: Select
Diagnostic Pediatric Radiology Fellowship
Pediatric Interventional Radiology Fellowship

Requested Start Date:

Contact Information:

Full Name: (First) (Last)

Previous Last Name: **SSN:**

Degree: MBBS

Email: **Pronouns:** Select

Gender (optional): Select **Birth Date (optional):**

Contact Address:

Permanent Mailing Address:

Mobile Phone #: **Home Phone #:**

Birth Place (optional):

Citizenship:

☐ **U.S Citizen**

☐ **Non- U.S. Citizen - Please indicate one of the following:**

Select

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If you are a foreign National, outside the U.S. or currently in the U.S. in valid visa status, please respond:

Select
B-1 (Temporary Visitor for Business)
F-1 (Academic Student)
H-1B (Temporary Worker in a Specialty Occupation)

Will you need "visa sponsorship" through ECFMG or the teaching hospital in order to participate in U.S. residency training?

☐ **Yes, please select one** Select ☐ **No** ☐ **Uncertain**

International Medical Graduates (IMGs) only:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

☐ **Yes ECFMG #:** _____ ☐ **No**

(Optional)

Are you committed to fulfill U.S. military active duty service obligations/deferments?

☐ **Yes, Years:** _____ **Branch:** _____ ☐ **No**

Do you have any other service obligations? (i.e., Military Reserves or Public Health/State programs)

☐ **Yes, please list:** _____ ☐ **No**

Examinations:

For each examination you have taken, please provide the requested information. Attach copies to application.

Exam: _____ Select

(Ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Exam: _____ Select

(Ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Exam: _____ Select

(Ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Board Certification Information:

Are you Board Certified? ☐ **No** ☐ **Yes, Board Name:** _____

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DEA Registration Information:

☐ **Not applicable**

☐ **DEA Registration Number *(if applicable)*:** _____ **Expiration Date:** _____

Medical Education:

For each medical educational institution you have attended, please provide the requested information.

Was your medical education/training extended or interrupted? ☐ **Yes** ☐ **No**

If no, please explain. _____

Institution #1: _____

City: _____ **State:** _____ **Country:** _____

Degree earned: ☐ **Yes, Degree:** _____ ☐ **No**

Date Received: _____

Dates of Attendance (*Leave month/year blank if experience is ongoing*):

From: _____ **To:** _____

Institution #2: _____

City: _____ **State:** _____ **Country:** _____

Degree earned: ☐ **Yes, Degree:** _____ ☐ **No**

Date Received: _____

Dates of Attendance (*Leave month/year blank if experience is ongoing*):

From: _____ **To:** _____

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Education (include only higher education):

For each non-medical educational institution you have attended, please provide the requested information.

Institution #1:

Location:

Education Type: ☐ **Undergraduate** ☐ **Graduate** ☐ **Other**

Field of Study:

Degree expected or earned: ☐ **Yes, Degree:** ☐ **No**

Date Received:

Dates of Attendance (*Leave month/year blank if experience is ongoing***):**

From:

Institution #2:

Location:

Education Type: ☐ **Undergraduate** ☐ **Graduate** ☐ **Other**

Field of Study:

Degree expected or earned: ☐ **Yes, Degree:** ☐ **No**

Date Recived:

Dates of Attendance (*Leave month/year blank if experience is ongoing***):**

From: **To:**

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Current/Prior Medical Training:

For each residency or fellowship training position you have held or currently are in, regardless of the amount of time spent there, please provide the requested information.

☐ **None**

Program 1: ☐ **Residency** ☐ **Fellowship** ☐ **Chief Resident**

Specialty:

Institution/Program:

Location:

Program Director:

Training Dates:

From: **To:**

Program 2: ☐ **Residency** ☐ **Fellowship** ☐ **Chief Resident**

Specialty:

Institution/Program:

Location:

Program Director:

Training Dates:

From: **To:**

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Licensure Information (Optional):

Entry 1:

State:

License Type: Select

License Number:

Expiration Date:

(If a License Number is provided, the expiration month and expiration year will be required.)

Entry 2:

State:

License Type: Select

License Number:

Expiration Date:

(If a License Number is provided, the expiration month and expiration year will be required.)

Is there anything in your past history that would limit your ability to be licensed or appointed to a graduate medical education training program?

☐ **No** ☐ **Yes**

If yes, please explain

Have you ever been named in a malpractice case?

☐ **No** ☐ **Yes**

If yes, please explain

For each state license you have, please provide the requested information.

☐ **Not Applicable**

Is there anything in your past history that would limit your ability to be licensed or appointed to a graduate medical education training program?

☐ **Yes** ☐ **No**

If yes, please explain

Are you able to carry out the responsibilities of a resident or fellow in the specialties and at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?

☐ **Yes** ☐ **No**

If yes, please explain

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I certify that the information contained within my application and all attachments and supplemental information, is complete and accurate to the best of my knowledge. I attest to the correctness and completeness of all information furnished. I understand that any false or missing information may disqualify me from consideration for a position; may result in an investigation by the AAMC per the AAMC Policies Regarding the Collection, Use and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data; may also result in expulsion from any match program; or if employed, may constitute cause for termination from the program. I authorize a representative of The Children's Hospital of Philadelphia to consult anyone who may have information bearing on my competence, ethics, character and other qualifications. I consent to the inspections, copying and release of all records and documents that may be material to evaluation of my competence, ethics, character and other qualifications. I release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information in good faith regarding my competence, ethics, character, and other qualifications, including otherwise confidential information.

Please ensure that each of the following documents is attached and submitted with this application:

- ☐ **Dean's letter aka Medical School Performance Evaluation (MSPE)**
- ☐ **Medical School Transcript**
- ☐ **Curriculum Vitae**
- ☐ **Personal Statement**
- ☐ **Photograph (optional)**
- ☐ **Copy of Passing Score Report for USMLE ☐ Step 1 ☐ Step2 CK ☐ Step 2 CS ☐ Step 3; OR;**
- ☐ **Copy of Passing Score Report for COMLEX ☐ Level 1 ☐ Level 2-CE ☐ Level 2-PE ☐ Level 3**
- ☐ **ECFMG Certification if a graduate of a medical school outside the U.S., Canada, or Puerto Rico**

References

At least four letters of recommendation from licensed physicians, one of which must be your residency or program director, concerning your professional ability must be submitted via email by the recommender. It is preferred that all references be submitted by individuals with whom you have trained.

Please list references below.

1. _____

2. _____

3. _____

4. _____

_____ _____

SIGNATURE OF APPLICANT **DATE**