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

FELLOWSHIP APPLICATION

<table>
<tr><td>Please attach recent photo

MUST BE INCLUDED to get an interivew</td><td>PLEASE DO NOT WRITE IN THIS SECTION

Appointment as:____

____

From:____________________ To:____________________</td></tr>
</table>

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): **Graduate Medical Training License (attach copy):**

State:__________________No.________________ State:__________________No:________________

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

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MEDICAL EDUCATION: Institution From To Degree

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

Hospital Location From To Degree

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POSTGRADUATE EDUCATION (organized courses only):

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____

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

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____

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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):

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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:

____

____

____

____

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____

SIGNATURE OF APPLICANT:____DATE:____________________

Return to:

Regular Mail Address
Amy Kim, MD, Program Director
c/o Mikki Pham, Fellowship Program Coordinator
2716 South Street
8th Floor, #8121
Philadelphia, PA 19146

Courier Address: