Children's Hospital of Philadelphia℠
3401 Civic Center Blvd. • Philadelphia, PA 19104 • 215-590-1000 • chop.edu

David N. Pincus Global Health Fellowship Application 2021-2024

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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

☐ Clinical Fellow, Specialty Area and preferred site_____
☐ Research Fellow, Specialty Area and preferred site_____

Contact Information:

Name: _____
Previous Last Name: _____
Medical School: _____
Medical/Dental Degree: _____
Email: _____
SSN: _____
Birth Place: _____
Birth Date: _____
Contact Address: _____
Permanent Mailing Address: _____
Preferred Phone #: _____
Home Phone #: _____

National Provider Information
(NPI) Number (if applicable) _____

Gender (optional) ☐ Male ☐ Female ■ Undesignated/non-binary ☐ I chose not to disclose

Citizenship:

☐ U.S Citizen
☐ Non- U.S. Citizen - Please indicate one of the following:
- ☐ Permanent Resident - *no visa required*
- ☐ Conditional Permanent Resident - *no visa required*
- ☐ Pending Applicant for Permanent Resident - *visa may be required*
- ☐ Refugee/Asylum/Displaced Person - *no visa required*
- ☐ Foreign National Residing Outside of the U.S.
- ☐ Foreign National Currently in the U.S. in Valid Visa Status

If you are a foreign National, outside the U.S. or currently in the U.S. with valid visa status, please respond: Select all that may apply from the list below:

☐B-1 – Temporary Visitor for Business
☐F-1 – Academic Student
☐H-1B – Temporary Worker in a Specialty Occupation
☐J-1 – Exchange Visitor
☐O-1 – Person of Extraordinary Ability in science, arts, education, business or athletics
☐TN – NAFTA Trade for Canadians and Mexicans

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

☐Yes, Please select one ☐H1-B or ☐J-1 ☐☐No ☐Uncertain

International Medical Graduates (IMGs) only:

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

☐Yes,Month:_____ Year: _____ ☐No

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,_____ ☐ No

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

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month:_____ Year:_____/ To: Month:_____ Year:_____ Leave month/year blank if experience is ongoing.

Institution #2: _____

Location: _____

Education Type: ☐Undergraduate ☐Graduate ☐Other

Field of Study: _____

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

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month:_____ Year:_____/ To: Month:_____ Year:_____ Leave month/year blank if experience is ongoing.

Medical Education:

Was your medical education/training extended or interrupted?

☐Yes ☐No Reason (up to 510 characters): _____

_____

_____

_____

Institution #1: _____

Location: _____

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

Degree Month:_____Degree Year: _____

Dates of Attendance:

From: Month:_____Year:_____/ To: Month:_____Year:_____Leave month/year blank if experience is ongoing.

Institution #2: _____

Location: _____

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

Degree Month:_____Degree Year: _____

Dates of Attendance:

From: Month:_____Year:_____/ To: Month:_____Year:_____Leave month/year blank if experience is ongoing.

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**

Training 1

Type of Training: ☐Residency ☐Fellowship ☐Chief Resident

Specialty: _____

Institution/Program: _____

Location: _____

No. of Years: _____

Program Director: _____

Dates of Residency/Fellowship/Osteopathic Training:

From: Month:_____Year:_____To: Month:_____Year: _____

Training 2

Type of Training: ☐Residency ☐Fellowship ☐Chief Resident

Specialty: _____

Institution/Program: _____

Location: _____

No. of Years: _____

Program Director: _____

Dates of Residency/Fellowship/Osteopathic Training:

From: Month:_____Year:_____To: Month:_____Year: _____

Training 3

Type of Training: ☐ Residency ☐Fellowship ☐ Chief Resident

Specialty: _____

Institution/Program: _____

Location: _____

No. of Years: _____

Program Director: _____

Dates of Residency/Fellowship/Osteopathic Training:

From: Month:_____ Year:_____ To: Month:_____ Year: _____

Examinations:

For each examination you have taken, please provide the requested information.

Exam:_____*(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐Passed ☐Failed ☐Awaiting Results ☐Will Take ☐Incomplete
Month:_____ Year: _____

Exam:_____*(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐Passed ☐Failed ☐Awaiting Results ☐Will Take ☐Incomplete
Month:_____ Year: _____

Exam:_____*(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐Passed ☐Failed ☐Awaiting Results ☐ Will Take ☐Incomplete
Month:_____ Year: _____

Exam:_____*(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐Passed ☐Failed ☐Awaiting Results ☐ Will Take ☐Incomplete
Month:_____ Year: _____

Board Certification Information:

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

DEA Registration Information:

☐ Not applicable, or

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

Expiration Month:_____ Expiration Year: _____

Licensure Information:

Has your medical license ever been suspended/revoked/voluntarily terminated?
☐No ☐Yes, Reason _____

Have you ever been named in a malpractice case?
☐No ☐Yes, Reason _____

Is there anything in your history that would limit your ability to be licensed or to receive hospital privileges?
☐ No ☐ Yes, Reason _____

_____

_____

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

☐ **Not Applicable, or**

Entry 1:

State: _____

License Type: ☐ Full ☐Temporary/ Limited ☐Inactive

License Number: _____

Expiration Month: _____ Expiration Year: _____

(If a License Number is provided, the Expiration Month and Expiration Year will be required.)

Entry 2:

State: _____

License Type: ☐ Full ☐Temporary/ Limited ☐Inactive

License Number: _____

Expiration Month: _____ Expiration Year: _____

(If a License Number is provided, the Expiration Month and Expiration Year will be required.)

Entry 3:

State: _____

License Type: ☐Full ☐ Temporary/ Limited ☐Inactive

License Number: _____

Expiration Month: _____ Expiration Year: _____

(If a License Number is provided, the Expiration Month and Expiration Year will be required.)

REFERENCES:

Communications concerning professional ability and personal qualifications must be sent separately directly to the appropriate Program Director 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:

Name: _____

Title: _____

Address: _____

Daytime Phone Number: _____

Email Address: _____

For how long has this reference known you? _____

In what capacity does this reference know you? _____

_____

_____

Name: _____

Title: _____

Address: _____

Daytime Phone Number: _____

Email Address: _____

For how long has this reference known you? _____

In what capacity does this reference know you? _____

_____

_____

Name: _____

Title: _____

Address: _____

Daytime Phone Number: _____

Email Address: _____

For how long has this reference known you? _____

In what capacity does this reference know you? _____

_____

_____

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, Limiting Aspects (up to 510 characters): _____

_____

_____

_____

☐ No Response _____

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
☐Copy of visa documentation if not a citizen or permanent resident of the U.S. (Permanent Residency Card, DS-2019 for current J1 visa holders, Copy of Form I-797 for current H1B visa holders)

SIGNATURE OF APPLICANT:_____DATE:_____

Please submit all documents by September 23, 2020 to:

Aimee Ortega
Fellowship Coordinator
David N. Pincus Global Health Fellowship
Global Health Center, Children's Hospital of Philadelphia
2716 South Street, 7th Fl., # 7410
Philadelphia, PA 19146

Phone: 267-425-7549
Email: ortegaa@email.chop.edu