THE CHILDREN'S HOSPITAL *of* PHILADELPHIA
34th Street and Civic Center Boulevard
Philadelphia, PA 19104-4399
Telephone: 215-590- 1190

RESIDENCY / FELLOWSHIP APPLICATION

Please attach recent photo	**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
□ Pediatric Level -2
□ Pediatric Level -3
□ Dental Resident
□ Surgical Resident
□ Clinical Fellow
□ Research Fellow

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:

"Please do not provide if already submitted to Division upon which you were interviewed"

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I certify that this Application, including all attachments and supplemental information, is true and correct to the best of my knowledge. I attest to the correctness and completeness of all information furnished. I fully understand that any significant misstatement or omission from this Application constitutes cause for denial of or dismissal from this educational opportunity. 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 inspection, 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.

SIGNATURE OF APPLICANT:_____DATE:_____

Return to:

Regular Mail Address

Valarie R. Todd
The Children's Hospital of Philadelphia
34th Street & Civic Center Blvd.
CHOP North, 12th Floor, Suite 1220
Philadelphia, PA 19104

Courier Address:

Valarie R. Todd
The Children's Hospital of Philadelphia
3535 Market Street
12th Floor, Suite 1220
Philadelphia, PA 19104