



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

FELLOWSHIP APPLICATION

| | | |
|---|---|--|
| <p>Please attach recent photo</p> <p>MUST BE INCLUDED to get an interview</p> | PLEASE DO NOT WRITE IN THIS SECTION | |
| | <p>Appointment as: _____</p> <p>_____</p> <p>From: _____ To: _____</p> | |

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 I _____ FLEX II _____ NBME I _____ 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:

Regular Mail Address

Tami D. Benton, MD
Director of Education
Dept. of Child & Adolescent Psychiatry
CHOP Behavioral Health Center
3440 Market Street, Suite 200
Philadelphia, PA 19104

Courier Address: