



THE CHILDREN'S HOSPITAL OF PHILADELPHIA

34th Street and Civic Center Boulevard

Philadelphia PA 19104-4399

Telephone (215) 590-1000

RESIDENCY, FELLOWSHIP, OBSERVER/VISITOR APPLICATION

Please attach recent photo

PLEASE DO NOT WRITE IN THIS SECTION
Appointment as _____

From _____ 19 ____ to _____ 19 ____

I hereby apply for appointment as a Graduate Medical Trainee or Observer/Visitor at 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 Ö APPOINTMENT DESIRED

- | | | |
|--|--|--|
| <input type="checkbox"/> Pediatric Level—1 | <input type="checkbox"/> Dental Resident | <input type="checkbox"/> Clinical Fellow |
| <input type="checkbox"/> Pediatric Level—2 | <input type="checkbox"/> Surgical Resident | <input type="checkbox"/> Research Fellow |
| <input type="checkbox"/> Pediatric Level—3 | <input type="checkbox"/> Observer/Visitor | <input type="checkbox"/> Other _____ |

Specialty _____

PLEASE TYPEWRITE OR PRINT

Name in Full _____ M.D. _____ M.B.B.S. _____ D.D.S. _____
D.O. _____ M.B.B.Ch. _____ D.M.D. _____

Present Address _____

City _____ State _____ Zip _____ Country _____

Telephone _____ Beeper No. _____ FAX No. _____

Permanent Address _____

City _____ State _____ Zip _____ Country _____

Place of Birth _____ Date of Birth _____ Married _____ Single _____

Citizen of _____ Social Security No. _____

Unrestricted Medical License (attach copy)

State _____ No. _____

State _____ No. _____

Graduate Medical Training License (attach copy)

State _____ No. _____

State _____ No. _____

Licensing Exams passed (attach copy of scores for each exam):

ECFMG English _____ LMCC _____ FLEX _____

State Board ___ FLEX I ___ FLEX II ___ NBME I ___ NBME II ___ NBME III ___ USMLE 1 ___ USMLE 2 ___ USMLE 3 ___

FOREIGN MEDICAL GRADUATES

ECFMG Certificate No. _____ (attach copy) Type of Visa _____ Held _____ Needed _____

12. PREMEDICAL EDUCATION College From To Degree

13. MEDICAL EDUCATION School From To Degree

14. HOSPITAL TRAINING Hospital and Location From To Degree
(DO NOT LIST ROTATIONS IN MEDICAL SCHOOL)

15. POSTGRADUATE EDUCATION (organized courses only): _____

16. Special training not already listed (assistantships, practice, etc.) _____

17. BOARD CERTIFICATION

Year	Specialty	Name of Board	Country of Issuing Board
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18. Additional information such as publications, summer work, extra curricular activities _____

19. REFERENCES: Communications concerning professional ability and personal qualifications must be sent under separate cover directly to The Children’s Hospital of Philadelphia from the Dean of your medical school, and at least three competent, recognized physicians, preferably under whom you have served or been trained. Letters of recommendation must be requested by the applicant.
List references below:

SIGNATURE OF APPLICANT _____ DATE _____

Return to: **Alan Jay Schwartz, MD, MEd**
Department of Anesthesiology & Critical Medicine
The Children’s Hospital of Philadelphia
34th Street & Civic Center Boulevard
Philadelphia, PA 19104-4399

**PLEASE INCLUDE AN EXTRA
PASSPORT SIZE PHOTO**

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