



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 APPOINTMENT DESIRED

- Pediatric Level-1, Pediatric Level-2, Pediatric Level-3, Dental Resident, Surgical Resident, Observer/Visitor, Clinical Fellow, Research Fellow, 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. Graduate Medical Training License (attach copy) 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: **Terrilynn Honesty**
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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