



34th Street and Civic Center Boulevard
 Philadelphia, PA 19104-4399
 Telephone 215-590-3856

APPLICATION FOR CLINICAL GENETICS TRAINING PROGRAM

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

Clinical Fellow Research Fellow Other: _____

Full Name: _____ 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 #: _____

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):

ECFMG English _____ TOEFL _____ Clinical Skills Assessment _____ LMCC _____ FLEX _____

State Board _____ 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 _____

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

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
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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 Ian Krantz, MD, The Division of Human Genetics 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: **Ian Krantz, MD**
 Division of Human Genetics
 The Children's Hospital *of* Philadelphia
 Abramson Research Center, Room 1002
 3615 Civic Center Boulevard
 Philadelphia, PA 19104-4399