



**THE CHILDREN'S HOSPITAL of PHILADELPHIA**  
**34<sup>th</sup> Street and Civic Center Boulevard**  
**Philadelphia, PA 19104-4399**  
**Telephone 215-590-3344**

**APPLICATION FOR PEDIATRIC NEPHROLOGY FELLOWSHIP**

<b>Please attach recent photo</b>	<b>PLEASE DO NOT WRITE IN THIS SECTION</b>	
	<b>Appointment as:</b> _____ _____ <b>From:</b> _____ <b>To:</b> _____	

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 \_\_\_\_\_

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PREMEDICAL EDUCATION:                      Institution                      From                      To                      Degree

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MEDICAL EDUCATION:                      Institution                      From                      To                      Degree

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HOSPITAL TRAINING (do not list rotations in medical school):

Hospital                      Location                      From                      To                      Degree

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POSTGRADUATE EDUCATION (organized courses only):

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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):

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REFERENCES: Communications concerning professional ability and personal qualifications must be sent under separate cover directly to Kevin E.C. Meyers, MBBCh, The Division of Pediatric Nephrology 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:

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\_\_\_\_\_

\_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_

**Return to:** Kevin E.C. Meyers, MB,BCh  
Division of Pediatric Nephrology  
The Children's Hospital *of* Philadelphia  
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