



THE CHILDREN'S HOSPITAL of PHILADELPHIA
34th Street and Civic Center Boulevard
Philadelphia, PA 19104-4399
Telephone 215-590-2791

APPLICATION FOR OCUOPLASTIC SURGERY FELLOWSHIP

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 _____

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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
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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 James A. Katowitz, MD, The Division of Pediatric Ophthalmology 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: James A. Katowitz, MD
Division of Pediatric Ophthalmology
The Children's Hospital *of* Philadelphia
34th Street and Civic Center Boulevard
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