



THE CHILDREN'S HOSPITAL of PHILADELPHIA

34<sup>th</sup> Street and Civic Center Boulevard

Philadelphia, PA 19104-4399

Telephone 215-590-2210

APPLICATION FOR PEDIATRIC PLASTIC 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).

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: \_\_\_\_\_ Cell phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 I \_\_\_\_\_ FLEX II \_\_\_\_\_ NBME I \_\_\_\_\_ NBME II \_\_\_\_\_ NBME III \_\_\_\_\_ USMLE I \_\_\_\_\_

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
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**ADDITIONAL INFORMATION** (such as publications, summer work, extra curricular activities):

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**REFERENCES:** A minimum of three references from physicians with whom you have trained regarding your professional abilities and personal qualification should be sent under separate cover to David W. Low, MD, Division of Plastic Surgery, The Children's Hospital of Philadelphia at the address listed below. Letters of recommendation must be requested by the applicant. List references below:

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

Return or email to: David W. Low, MD  
Division of Plastic Surgery  
The Children's Hospital of Philadelphia  
34th and Civic Center Boulevard  
Wood Ambulatory Care Building, 1st Floor  
Philadelphia, PA 19104-4399

low@email.chop.edu  
FAX: 215-590-2496