



THE CHILDREN'S HOSPITAL of PHILADELPHIA
34th Street and Civic Center Boulevard
Philadelphia, PA 19104-4399
Telephone: 215-590- 5357

CHILD ABUSE PEDIATRICS FELLOWSHIP APPLICATION

Attach recent photo (Optional)	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: _____

Degree(s) (Check all that apply): MD DO JD MHS MSc MSW
 MEd MPH MSCE MBA PhD

E-Mail Address: _____

Preferred Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Preferred Phone: _____ Alternate Phone: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Social Security Number: _____

Citizenship: _____ Visa Type (attach copy): _____

Optional Information:

Birthdate: _____ Birthplace: _____

Gender: Female Male Married Single



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U.S. LICENSING EXAMS PASSED (attach copy of scores for each exam):

- USMLE Step 1 USMLE Step 2 CK USMLE Step 2 CS USMLE Step 3
 COMLEX Level 1 COMLEX Level 2 CK COMLEX Level 2 PE COMLEX Level 3

INTERNATIONAL MEDICAL GRADUATES:

Are you certified by ECFMG? Yes (attach copy of certificate) Certification Date: _____ No

STATE MEDICAL LICENSES:

Type (Full or Temporary/Limited)	Number	State	Exp. Date

MEDICAL EDUCATION:

Education	Institution & Location	Dates Attended	Degree	Degree Date	Field of Study

EDUCATION:

Education	Institution & Location	Dates Attended	Degree	Degree Date	Field of Study

CURRENT/PRIOR MEDICAL TRAINING:

Experience (Residency/Fellowship)	Institution & Location	Discipline	Program Director	Dates of Training	Number of Years

BOARD CERTIFICATION:

Yes/No	If Yes, Discipline	Certification Date	Name of Board	Country of Issuing Board



ADDITIONAL INFORMATION (such as research, publication, awards/accomplishments):

REFERENCES: Communications concerning professional ability and personal qualifications must be sent under separate cover directly to Philip Scribano, DO, MSCE at the address noted below, from at least three (3) physicians, preferably under whom you have served or trained. **Letters of recommendation must be requested by the applicant.** List references below:

Name	Title	Institution	Relationship

I certify that this Application, including all attachments and supplemental information, is true and correct to the best of my knowledge. I attest to the correctness and completeness of all information furnished. I fully understand that any significant misstatement or omission from this Application constitutes cause for denial of or dismissal from this educational opportunity. I authorize a representative of The Children's Hospital of Philadelphia to consult anyone who may have information bearing on my competence, ethics, character and other qualifications. I consent to the inspection, copying and release of all records and documents that may be material to evaluation of my competence, ethics, character and other qualifications. I release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information in good faith regarding my competence, ethics, character, and other qualifications, including otherwise confidential information.

SIGNATURE OF APPLICANT: _____ DATE: _____

Return to:

Philip Scribano, DO, MSCE
Division of General Pediatrics
The Children's Hospital of Philadelphia
34th Street & Civic Center Blvd., 12NW56
Philadelphia, PA 19104