Children's Hospital of Philadelphia
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LEAH
LEADERSHIP EDUCATION IN ADOLESCENT HEALTH

The Children's Hospital of Philadelphia
Leadership Education in Adolescent and Young Adult Health Program (LEAH)
Application for Fellowship
2026-2027

Personal Information

Name: _____ Date: _____

Current Street Address: _____ City: _____

_____

State: _____ Zip Code: _____

Email Address: _____ Telephone: _____

CHOP Email Address: _____

The Children's Hospital of Philadelphia does not discriminate on the basis of age, race, ethnicity, national origin, religion, sex, gender, sexual orientation, gender identity, handicap, or veteran status in provision of educational opportunities and benefits.

Citizenship	
Are You a US Citizen? ☐ Yes ☐ No	If no, admitted to the U.S. with a permanent resident Visa**?** ☐ Yes ☐ No

Training Information	
Applicant's Profession/ Discipline: ☐ Medicine ☐ Nursing ☐ Nutrition ☐ Psychology ☐ Social Work ☐ Other:	Name of CHOP or PENN preceptor(s): (If unknown write "unknown")
Highest Degree Completed:	
Will this training be applied toward achievement of a degree? ☐ Yes ☐ No	IF YES, from what institution? Credentials after completion of Fellowship:
MCHB funders request we collect information on self-reported race and ethnicity. What race are you? Mark all that apply. ☐African American/Black ☐Asian/Pacific Islander ☐ Caucasian/White ☐ Other: ☐ Prefer not to respond	What ethnicity are you? Mark all that apply. ☐ Hispanic ☐ Non-Hispanic ☐ Other: ☐ Prefer not to respond

Required Application Materials:

1. **Completed LEAH Application**
2. **Cover letter that describes why you are applying for a LEAH fellowship, and places this within the context of your training and career goals.**
3. **A copy of your academic transcript(s).**
4. **Curriculum Vitae or CV/Résumé**
5. **Signed affidavit below.**
6. (NOTE: Three Letters of Reference may be requested from finalists.)

AFFIDAVIT: I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever. I agree that the agency shall not be liable in any respect if my training is terminated because of the falsity of statements, answers or omissions made by me in this questionnaire. In addition, if accepted, I hereby agree to abide by the rules and policies of the Children's Hospital of Philadelphia and its affiliating agencies.

Signature: _____ Date: _____

RETURN ONE PACKET CONTAINING ALL APPLICATION MATERIALS TO:

Bea Chestnut
LEAH Program Manager
Division of Adolescent Medicine
3501 Civic Center Blvd.
Hub Building, 14th floor, Room 14594
Philadelphia, PA 19104-4399
chestnut@chop.edu
W: 267-426-3938 (6-3938)
Fax: 215-590-4708