



**Nicklaus
Children's
Hospital**

Common Application for Nicklaus Children's Hospital Training Programs

Application for Academic Year 20_____ - 20_____

Application for the following Training Program: _____

PERSONAL DATA:

Name (First, Middle, Last):	
Current Mailing Address:	
Permanent Mailing Address:	
Telephone Numbers:	Home:
	Cell:
Email Address:	
Social Security Number:	
Date of Birth:	
Place of Birth:	
Citizenship:	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> J-1 Visa <input type="checkbox"/> Other _____

EDUCATION:

<u>Degrees</u>	<u>School</u>	<u>Degree & Date Completed</u>
Undergraduate:		
Medical School:		
Other:		

POST GRADUATE TRAINING:

<u>Title</u>	<u>Institution</u>	<u>Date Completed</u>
PGY 1		
PGY 2		
PGY 3		
Other		

USMLE/COMLEX Scores:	USMLE Step 1 / COMLEX Level 1:
(type in score)	USMLE Step 2 CK/ COMLEX Level 2 CE:
	USMLE Step 2 CS/ COMLEX Level 2 PE:
	USMLE Step 3/ COMLEX Level 3:
ECGMG Certification (IMG):	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date of certification:

Medical Licensure:	State:	Number:
	Type:	Expiration:

Awards, Honors, and Academic Achievements:

Professional Societies and Committee Memberships:

Research and Other Scholarly Activities:

Advocacy, Volunteer and Extracurricular Activities:

Other Work Experience:

Licensure Background Information:
Was your medical education/training extended or interrupted? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please submit an explanation)
Has your medical license ever been suspended/revoked/voluntarily terminated? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please submit an explanation)
Have you ever been named in a malpractice suit? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please submit an explanation)
Have you ever been convicted of a misdemeanor? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please submit an explanation)
Have you ever been convicted of a felony? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please submit an explanation)

PROFESSIONAL REFERENCES: (List Three)

(1) Name:
Address:
Phone:
Email:
(2) Name:
Address:
Phone:
Email:
(3) Name:
Address:
Phone:
Email:

CHECKLIST FOR COMPLETION OF APPLICATION:

Please complete the application electronically. Print, sign and send the application to the attention of the program director with the below documents attached:

- Completed and signed application (including a 2x2 photo)
- Curriculum Vitae (please include months and years)
- Personal Statement (one page)
- Medical School Diploma
- Medical School Transcripts (unofficial or copies is allowable)
- Letter of Support from Current Training Program Director
- USMLE/COMLEX Transcript
- Three (3) letters of recommendation (In addition to the letter from current training program director) – To be sent via email by the letter writer directly to the NCH Program Director

ATTESTATION:

I certify that the information contained in this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position or may be grounds for termination from the program if employed. I also understand and agree that the information included in this application may be shared with members of the program’s Selection Committee.

Signature of Applicant

Date

Please submit the completed application and supporting documents to the Program Coordinator listed on the individual program website.