Application for Miami Children's Hospital
_____ Fellowship Program

Application for Fellowship for Academic Year 20__ - 20__

PERSONAL DATA:

Name:	**(type your name here)**
Current Mailing Address:	
Permanent Mailing Address:	
Telephone Numbers:	**Day:**
	Evening:
Email Address:	
Social Security Number:	
Date of Birth:	
Place of Birth:	
☐ **U.S.** ☐ Permanent	☐ J-1 ☐ Other

EDUCATION:

Degrees	**School**	**Date Completed**
Undergraduate:		
Medical School:		
Other:		

POST GRADUATE TRAINING:

Title	**Institution**	**Date Completed**
PGY 1		
PGY 2		
PGY 3		
Other		

USMLE:	Step 1:	
(type in score)	Step 2:	CSA:
	Step 3:	
Licensure:	State:	Year:

Awards, Honors, and Memberships in Professional Societies:

Academic and Committee Memberships:

PROFESSIONAL REFERENCES: (List Three)

(1)
(2)
(3)

CHECKLIST FOR COMPLETION OF APPLICATION:

- ☐ Completed and signed application (including a 2x2 photo, optional)
- ☐ Curriculum Vitae (please include months and years)
- ☐ Personal Statement (one page)
- ☐ Medical School Diploma copy
- ☐ Residency Diploma copy (if applicable)
- ☐ USMLE Score copies
- ☐ Three (3) letters of recommendation (one must be written by the Director of your Residency Program or Chair of your Department; must be in sealed envelopes)
- ☐ Medical School Transcripts (unofficial or copies is allowable)

Please complete the application electronically. Print, sign and mail the application to the appropriate program director and address above.

_____ _____

Signature of Applicant Date