PEDIATRIC HOSPITAL MEDICINE FELLOWSHIP PROGRAMS
SHARED APPLICATION
ACADEMIC YEAR 2019-2020

Profile

First Name:
Middle Name:
Last Name:
Suffix:
Previous Last Name:
Contact Email:
Phone:

Please attach a recent photo:

Mailing Address

Mailing Address: Click here to enter text.

Self Identification (Optional)

Please select all that apply.

☐Hispanic, Latino or of Spanish Origin

- ☐Colombian
- ☐Argentinian
- ☐Cuban
- ☐Dominican
- ☐Mexican/Chicano
- ☐Peruvian
- ☐Puerto Rican
- ☐Other Hispanic:

☐American Indian or Alaskan Native

- ☐Tribal affiliation:

☐Black or African American

☐Asian

- ☐Bangladeshi
- ☐Cambodian
- ☐Chinese
- ☐Filipino
- ☐Indian
- ☐Indonesian
- ☐Japanese
- ☐Korean
- ☐Laotian
- ☐Pakistani
- ☐Taiwanese
- ☐Vietnamese
- ☐Other Asian:

☐Native Hawaiian or Pacific Islander

☐African American
☐Afro-Caribbean
☐African
☐Other Black:

☐Guamanian
☐Native Hawaiian
☐Samoan
☐Other Pacific Islander:

☐White

☐Other:Click or tap here to enter text.

Citizenship

☐US Citizen ☐US Resident ☐Other:
If you are a foreign national outside the US, or currently in the US in valid visa status, please respond or type N/A:

Will you need a "visa sponsorship" through the teaching hospital (J1, H1B, etc.) in order to participate in US fellowship training? ☐Yes ☐No

If yes to above:

- Please specify type of Visa:
- Did you train at a foreign medical school? ☐Yes ☐No
- Is your medical school listed on the approved list for state licenses to which you will be applying? If unsure, please contact the programs to which you will be applying? ☐Yes ☐No ☐Unsure
    - If you are unsure, please contact the programs to which you are applying. Obtaining state license for the state in which you will be training is mandatory in order to begin fellowship.

USMLE/COMLEX/ECFMG/TOEFL Scores

USMLE:
Step 1:
Step 2 CK:
Step 2 CS:
Step 3:

COMLEX:
Level 1:
Level 2 CE:
Level 2 PE:
Level 3:

ECFMG:
Score:

TOEFL:
Score:

Licensure Information

Has your medical license ever been suspended / revoked/ voluntarily terminated?
☐Yes ☐No If yes, please enter date:
If yes, please comment:

Have you ever been named in a malpractice case?

☐Yes ☐No If yes, please comment:

Is there anything in your past history that would limit your ability to be licensed or would limit your ability to receive hospital privileges?
☐Yes ☐No If yes, please comment:

Board Certification

Are you Board Certified? ☐Yes ☐No If no, will you be Board Eligible by the beginning of fellowship? ☐Yes ☐No

Board Name:

If Board certified/eligible for more than one Board:

Are you Board Certified? ☐Yes ☐No If no, will you be Board Eligible by the beginning of fellowship? ☐Yes ☐No

Board Name:

Medical Licenses

This section allows entries for each of your state medical licenses.
☐None

Entry 1

State: License Number:
License Type: Expiration Month / Year:

Entry 2

State: License Number:
License Type: Expiration Month / Year:

DEA Number *(Note: DEA is for US Medical License holders only)*

DEA Registration Number: Expiration Month/Year:

Miscellaneous

Are you able to carry out the responsibilities of a fellow in Pediatric Hospital Medicine and at the specific training program to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?

☐Yes ☐No If no, please comment:

Was your medical education / training extended or interrupted?

☐Yes ☐No If yes, please comment:

Letters of Recommendation

Please provide three letters of recommendation. If within 5 years of residency training, one of these letters must be from your residency program director. Your letter writers can send their letters directly by e-mail to the Program Director at the address listed below in the Appendix.

Reference 1

Name & Contact Information:

Reference 2

Name & Contact Information:

Reference 3

Name & Contact Information:

Personal Statement

Please attach a <u>one</u> page personal statement explaining why you want to do a fellowship in Pediatric Hospital Medicine. Please include a description of your five year career goals, how the fellowship will assist you in achieving them, and potential scholarly project(s) you might pursue during fellowship. Broad areas for scholarly projects include, but are not limited to: clinical research, quality improvement, medical education, clinical informatics, advocacy, global health, and public policy.

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 if employed, may constitute cause for termination from the program. I also understand and agree that the data included in this application may be shared within the fellowship programs to which I am applying.

☐ I Agree

Checklist for Submission - The below documents should be emailed directly to the email address in the Shared Application Program List document

☐This completed application form (including personal statement)

☐An updated CV

☐Three Letters of Recommendation to be sent directly by letter writer to the Program Director. If a current resident, one letter must be from your current Program Director.