THE CHILDREN'S HOSPITAL *of* PHILADELPHIA
34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399

CHOP Common Graduate Medical Education Application Form

Attach recent photo

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).

PLEASE ✓ APPOINTMENT DESIRED

☐ Clinical Fellow, Specialty Area _____
☐ Research Fellow, Specialty Area _____

Contact Information:

Name: _____
Previous Last Name: _____
Medical School: _____
Medical/Dental Degree: _____
Email: _____
SSN: _____
Contact Address: _____
Permanent Mailing Address: _____
National Provider Information
(NPI) Number _____
Preferred Phone #: _____
Home Phone #: _____

Citizenship:

☐ U.S Citizen
☐ Non- U.S. Citizen - Please indicate one of the following:
- ☐ Permanent Resident - *no visa required*
- ☐ Conditional Permanent Resident - *no visa required*
- ☐ Pending Applicant for Permanent Resident - *visa may be required*
- ☐ Refugee/Asylum/Displaced Person - *no visa required*
- ☐ Foreign National Residing Outside of the U.S.
- ☐ Foreign National Currently in the U.S. in Valid Visa Status

If you are a foreign National, outside the U.S. or currently in the U.S. in valid visa status, please respond:
Select all that may apply from the list below:
- ☐ B-1 – Temporary Visitor for Business
- ☐ F-1 – Academic Student
- ☐ H-1B – Temporary Worker in a Specialty Occupation
- ☐ J-1 – Exchange Visitor
- ☐ O-1 – Person of Extraordinary Ability in science, arts, education, business or athletics
- ☐ TN – NAFTA Trade for Canadians and Mexicans

Will you need "visa sponsorship" through ECFMG or the teaching hospital in order to participate in U.S. residency training? Select one:

☐ Yes, Please select one ☐ H1-B or ☐ J-1 ☐ No ☐ Uncertain

Miscellaneous Demographic Information:

Please provide your current **veteran status**:

☐ Active Military Duty ☐ Reservist ☐ Veteran (Prior Service) ☐ Veteran (Retired) ☐ Not a Veteran

Are you committed to fulfill U.S. military active duty service obligations/deferments? *

☐ Yes, Years: _____ Branch: _____ ☐ No

Do you have any other service obligations? (i.e., Military Reserves or Public Health/State programs) *

☐ Yes, _____ ☐ No

Please advise if you are from a **disadvantaged background status*** ☐ Yes ☐ No

Disadvantaged background is a citizen, national, or a lawful permanent resident of the United States or the District of Columbia, the Commonwealths of Puerto Rico or the Marianas Islands, the Virgin Islands, Guam, the American Samoa, the Trust Territory of the Pacific Islands, the Republic of Palau, the Republic of the Marshall Islands and the Federated State of Micronesia who either:

- *Comes from an environment that has inhibited the individual from obtaining the knowledge, skill, and abilities required to enroll in and graduate from a health professions school, or from a program providing education or training in an allied health profession*
  OR
- *Comes from a family with an annual income below a level based on low income thresholds according to family size published by the U.S. Bureau of Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary, HHS, for use in health professions and nursing programs.*

So that we can determine if you are from a **rural residential background**, please provide the state and county in which you currently have established residence:

State: _____ County: _____

International Medical Graduates (IMGs) only:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

☐ Yes, Month: _____ Year: _____ ☐ No

If Yes, Attach Certificate

Education (include only higher education):

For each non-medical educational institution you have attended, please provide the requested information.

Institution #1: _____

Location: _____

Education Type: ☐ Undergraduate ☐ Graduate ☐ Other

Field of Study: _____

Degree expected or earned: ☐ Yes, Degree: _____ ☐ No

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month: _____ Year:_____ / To: Month: _____ Year: _____ Leave month/year blank if experience is ongoing.

Institution #2: _____

Location: _____

Education Type: ☐ Undergraduate ☐ Graduate ☐ Other

Field of Study: _____

Degree expected or earned: ☐ Yes, Degree: _____ ☐ No

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month: _____ Year:_____ / To: Month: _____ Year: _____ Leave month/year blank if experience is ongoing.

Medical Education:

Was your medical education/training extended or interrupted?

☐ Yes ☐ No Reason (up to 510 characters): _____

_____

_____

_____

Institution #1: _____

Location: _____

Degree expected or earned: ☐ Yes, Degree: _____ ☐ No

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month: _____ Year:_____ / To: Month: _____ Year: _____ Leave month/year blank if experience is ongoing.

Institution #2: _____

Location: _____

Degree expected or earned: ☐ Yes, Degree: _____ ☐ No

Degree Month: _____ Degree Year: _____

Dates of Attendance:

From: Month: _____ Year:_____ / To: Month: _____ Year: _____ Leave month/year blank if experience is ongoing.

Current/Prior Medical Training:
For each residency or fellowship training position you have held or currently are in, regardless of the amount of time spent there, please provide the requested information.

☐ **None**

Type of Training: ☐ Residency ☐ Fellowship ☐ Chief Resident
Specialty: ____
Institution/Program: ____
Location: ____
Program Director: ____
No. of Years: ____________________
Dates of Residency/Fellowship Training:
From: Month: ___________ Year: _____ To: Month: ___________ Year: _____

Type of Training: ☐ Residency ☐ Fellowship ☐ Chief Resident
Specialty: ____
Institution/Program: ____
Location: ____
Program Director: ____
No. of Years: ____________________
Dates of Residency/Fellowship Training:
From: Month: ___________ Year: _____ To: Month: ___________ Year: _____

Type of Training: ☐ Residency ☐ Fellowship ☐ Chief Resident
Specialty: ____
Institution/Program: ____
Location: ____
Program Director: ____
No. of Years: ____________________
Dates of Residency/Fellowship Training:
From: Month: ___________ Year: _____ To: Month: ___________ Year: _____

Examinations:
For each examination you have taken, please provide the requested information. ***Copies of score reports must be attached.***

Exam: ______________________________ *(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐ Passed ☐ Failed ☐Awaiting Results ☐ Will Take ☐ Incomplete
Month: _________________ Year: _________________

Exam: ______________________________ *(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐ Passed ☐ Failed ☐Awaiting Results ☐ Will Take ☐ Incomplete
Month: _________________ Year: _________________

Exam: _____ *(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐ Passed ☐ Failed ☐Awaiting Results ☐ Will Take ☐ Incomplete
Month: _____ Year: _____

Exam: _____ *(ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)*
☐ Passed ☐ Failed ☐Awaiting Results ☐ Will Take ☐ Incomplete
Month: _____ Year: _____

Board Certification Information:
Are you Board Certified? ☐ No ☐ Yes, Board Name: _____

DEA Registration Information:

☐ Not applicable, or

☐ DEA Registration Number: _____ *(if applicable)*

Expiration Month: _____ Expiration Year: _____

Licensure Information:
Has your medical license ever been suspended/revoked/voluntarily terminated?
☐ No ☐ Yes, Reason _____
_____
_____

Have you ever been named in a malpractice case?
☐ No ☐ Yes, Reason _____
_____
_____

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?
☐ No ☐ Yes, Reason _____
_____
_____

For each state license you have, please provide the requested information.

☐ **Not Applicable, or**

Entry 1:

State: _____

License Type: ☐ Full ☐ Temporary/ Limited ☐ Inactive

License Number: _____

Expiration Month: _____ Expiration Year: _____

(If a License Number is provided, the Expiration Month and Expiration Year will be required.)

Entry 2:

State: _____

License Type: ☐ Full ☐ Temporary/ Limited ☐ Inactive

License Number: _____

Expiration Month: _____ Expiration Year: _____

(If a License Number is provided, the Expiration Month and Expiration Year will be required.)

Entry 3:

State: _____

License Type: ☐ Full ☐ Temporary/ Limited ☐ Inactive

License Number: _____

Expiration Month: _____ Expiration Year: _____

(If a License Number is provided, the Expiration Month and Expiration Year will be required.)

Are you able to carry out the responsibilities of a resident or fellow in the specialties and at the specific training programs 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, Limiting Aspects (up to 510 characters): _____

_____

_____

_____

☐ No Response _____

I certify that the information contained within my application and all attachments and supplemental information, is complete and accurate to the best of my knowledge. I attest to the correctness and completeness of all information furnished. I understand that any false or missing information may disqualify me from consideration for a position; may result in an investigation by the AAMC per the AAMC Policies Regarding the Collection, Use and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data; may also result in expulsion from any match program; or if employed, may constitute cause for termination from the program. 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 inspections, 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:

Regular Mail Address

Alex May
Pediatric Critical Care Medicine Fellowship
Department of Anesthesiology and Critical Care Medicine
The Children's Hospital of Philadelphia
3401 Civic Center Boulevard
Wood Building; Suite 6025
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Email: maya2@email.chop.edu

Courier (UPS/FedEx) Address:

Alex May
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