THE CHILDREN'S HOSPITAL *of* PHILADELPHIA
3401 Civic Center Boulevard, Philadelphia, PA 19104-4399

CHOP Common Graduate Medical Education Application Form

Attach recent photo (optional)

I hereby apply for appointment as a Graduate Medical Trainee as follows:

Program: Select
Academic General Pediatrics
Acute Care Global Health
Advanced Pediatric Neurocritical Care – Critical Care Track

Requested Start Date:

Contact Information:

Full Name: (First) (Last)

Previous Last Name: N/A

Email: SSN:

Medical Degree: Select

Dental Degree: Select

Other Degrees: Select

Contact Address:

Permanent Mailing Address:

Mobile Phone #: **Home Phone #:**

International Medical Graduates (IMGs) only:

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

☐ **No** ☐ **Yes, please select requested category/categories:** Select

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

☐ **Yes** **ECFMG #:** ☐ **No**

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Examinations:

For each examination you have taken, please provide the requested information. Attach copies to application.

Exam: _____ Select

(Ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Exam: _____ Select

(Ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Exam: _____ Select

(Ex. USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)

Board Certification Information:

Are you Board Certified?

☐ **No**

☐ **Yes, Board Name:** _____ **Country:** _____

DEA Registration Information:

☐ **Not applicable**

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

Medical Education:

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

Was your medical education/training extended or interrupted? ☐ **Yes** ☐ **No**

If no, please explain.

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Institution #1:

City: **State:** **Country:**

Degree earned: ☐ **Yes, Degree:** ☐ **No**

Date Received:

Dates of Attendance (*Leave month/year blank if experience is ongoing*):

From: **To:**

Institution #2:

City: **State:** **Country:**

Degree earned: ☐ **Yes, Degree:** ☐ **No**

Date Received:

Dates of Attendance (*Leave month/year blank if experience is ongoing*):

From: **To:**

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**

Date Received:

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Dates of Attendance (*Leave month/year blank if experience is ongoing*):

From: _____ **To:** _____

Institution #2: _____

Location: _____

Education Type: ☐ **Undergraduate** ☐ **Graduate** ☐ **Other**

Field of Study: _____

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

Date Received: _____

Dates of Attendance (*Leave month/year blank if experience is ongoing*):

From: _____ **To:** _____

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**

Program #1: ☐ **Residency** ☐ **Fellowship** ☐ **Chief Resident**

Specialty: _____

Institution/Program: _____

Location: _____

Program Director: _____

Training Dates:

From: _____ **To:** _____

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Program #2: ☐ **Residency** ☐ **Fellowship** ☐ **Chief Resident**

Specialty:

Institution/Program:

Location:

Program Director:

Training Dates:

From: **To:**

Licensure Information:

For each state license you have, please provide the requested information. If a License Number is provided, the expiration month and expiration year will be required.

Entry #1:

State:

License Type: Select

License Number:

Expiration Date:

Entry #2:

State:

License Type: Select

License Number:

Expiration Date:

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Has your medical license ever been suspended/revoked/voluntarily terminated?

☐ **No** ☐ **Yes**

If yes, please explain

Have you ever been named in a malpractice case?

☐ **No** ☐ **Yes**

If yes, please explain

Optional Diversity Information:

Graduate Medical Education Training Programs at CHOP seek to draw trainees from diverse backgrounds. The information requested below will be used to evaluate the effectiveness of our recruitment efforts. This information is confidential and completely voluntary. Answering the questions or the omission of an answer will not influence the application review process.

Gender: Select **Race/Ethnicity:** Select

Birth Date: **Birth Place:**

Citizenship:

☐ **U.S Citizen**

☐ **Non- U.S. Citizen - Please indicate one of the following:**

Select

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: Select
B-1 – Temporary Visitor for Business
F-1 – Academic Student

Military:

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**

Other Optional Information

Is there anything in your past history that would limit your ability to be licensed or appointed to a graduate medical education training program?

☐ **No** ☐ **Yes**

If yes, please explain

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?

☐ **No** ☐ **Yes**

If yes, please explain

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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.

Please ensure that each of the following documents is attached and submitted with this application:

- ☐ **Dean's letter aka Medical School Performance Evaluation (MSPE)**
- ☐ **Medical School Transcript**
- ☐ **Curriculum Vitae**
- ☐ **Personal Statement**
- ☐ **Photograph (optional)**
- ☐ **Copy of Passing Score Report for USMLE ☐ Step 1 ☐ Step2 CK ☐ Step 2 CS ☐ Step 3; OR;**
- ☐ **Copy of Passing Score Report for COMLEX ☐ Level 1 ☐ Level 2-CE ☐ Level 2-PE ☐ Level 3**
- ☐ **ECFMG Certification if a graduate of a medical school outside the U.S., Canada, or Puerto Rico**

References

Letters of recommendations from at least 4 physicians, one of which must be your residency or fellowship program director concerning your professional ability and personal qualifications must be submitted. It is preferred that all references be submitted by individuals with whom you have trained.

Please list references below.

1. _____

2. _____

3. _____

4. _____

_____ _____

SIGNATURE OF APPLICANT **DATE**

Please return completed application to