CHAM ACADEMIC GENERAL PEDIATRICS FELLOWSHIP PROGRAM APPLICATION

Profile

First Name:	
Middle Name:	
Last Name:	
Suffix:	
Previous Last Name:	
Contact Email:	
Date of Birth:	
Phone:	
Emergency Contact (Name and Number):	

Mailing Address

Street Address:	
City:	
State/Province:	
Zip/Postal Code:	

Citizenship

☐ US Citizen

☐ US Permanent Resident

☐ Other (Please list):

If you are a foreign national outside the US, or currently in the US on a valid visa status, will you need a "visa sponsorship" through the teaching hospital (J1, H1B, etc.) to participate in US fellowship training? ☐ Yes ☐ No

(IF NO, SKIP TO THE SECTION LABELED "EDUCATION SECTION: General educational information" below the ECFMG/TOEFL scores)

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? ☐ 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 to being fellowship.*

ECFMG/TOEFL Scores
Please provide documentation for your ECFMG and/or TOEFL scores in the space below.

EDUCATION SECTION: General Education Information

College/University:		From:		To:	
City, State:		Degree:			
Medical School:		From:		To:	
City, State:		Degree:			
Internship:		From:		To:	
City, State:		Degree:			
Residency:		From:		To:	
City, State:		Degree:			
Other Training:		From:		To:	
City, State:		Degree:			

1. Was your medical education/training extended or interrupted?

   ☐ Yes ☐ No

   If yes, please note the date and comment:

Licensure Information

This section allows entries for each of your state medical licenses.

Have you passed the USMLE Step 3? ☐ Yes ☐ No

☐ No current medical license (If you do not have a current medical license, skip to the "Board Certification" questions.)

Entry 1			
State:		License Number:	
License Type:		Expiration Month/Year:	
Entry 2			
State:		License Number:	
License Type:		Expiration Month/Year:	
DEA Number *(DEA is for US Medical License holders only.)*			
DEA Registration Number		Expiration Month/Year:	

1. Has your medical license ever been suspended / revoked/ voluntarily terminated?
   ☐ Yes ☐ No
   If yes, please note the date and comment:

2. Have you ever been named in a malpractice case? ☐ Yes ☐ No
   If yes, please note the date and comment:

3. Is there anything in your past history that would limit your ability to be licenses or would limit your ability to receive hospital privileges? ☐ Yes ☐ No
   If yes, please note the date and comment:

Board Certification

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

Board Name:

Are you Board Certified/eligible for more than one Board? ☐ Yes ☐ No
If no, will you be Board Eligible by the beginning of the fellowship? ☐ Yes ☐ No

Board Name:	

Miscellaneous

Are you able to carry out the responsibilities of a fellow in Academic General Pediatrics 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:

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 or his or her designee. Your letter writers can send their letters directly by e-mail to the Program Director (Dr. Suzette Oyeku, soyeku@montefiore.org) and Associate Director (Dr. Sylvia Lim, slim@montefiore.org).
Please fill out the Confidential Reference Report for each of your recommenders and submit a Confidential Reference Report along with each letter of recommendation.

Reference 1

Name:	
Contact Information:	

Reference 2

Name:	
Contact Information:	

Reference 3

Name:	
Contact Information:	

Personal Statement

Please attach one page personal statement explaining why you want to do a fellowship in Academic General Pediatrics and/or Primary Care. Please include a description of your career goals, how the fellowship may assist you in achieving them, your scholarly/research interests, and how you envision your career five years after completion of this fellowship. You may want to include how past experiences have influenced your decision to apply and mention special areas of interest. *(Make sure your name appears on the attachment.)*

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 with the attestation.

Date: _____

Supplemental Biographical Information

The information requested is for statistical purposes only and will not be used during consideration of the application.

Date of Birth:	
Place of Birth:	
Gender:	

Ethnicity/Race (Self-identification):

Ethnicity

☐ Of Hispanic or Latino origin (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race).

☐ Not of Hispanic or Latino origin

Race

☐ Black or African American: A person having origins in any of the original groups of Africa.

☐ Asian or Asian-American: Includes persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent (e.g. Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).

☐ American Indian or Alaskan native: Includes persons having origins in any of the original peoples of North America and South American (including Central America), who mains tribal affiliation or community attachment.

☐ Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

☐ White: Includes persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

Disadvantaged Background:

An individual from a disadvantaged background is defined as someone who: Comes from an environment that has inhibited the individual from obtaining the knowledge, skills, 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 the Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary of Health and Human Services for use in health professions and nursing programs.

☐ Yes ☐ No