Application for Fellowship

Division: Neurology – Epilepsy
Phone: 513-636-7558 Fax: 513-636-1888
Email: Terri.Feist@cchmc.org

Mail completed application to: Cincinnati Children's Hospital Medical Center
Division of Neurology
Attention: Terri Feist
3333 Burnet Avenue, MLC 2015
Cincinnati, Ohio 45229-3039

Desired Starting Date of Appointment:_____ Are you a US citizen? Yes No_____ If no, Visa type:_____
Are you eligible or authorized to work in the US? Yes_____No____

Name: _____ Social Security No.: _____
Last *First* *Middle (complete)* *Maiden (if applicable)*

Present Address: _____ Telephone: (____)_____Day
_____ (____)_____Evening
Permanent Address: _____ Telephone: ( ) _____
_____

E-mail address: _____ Pager Number: _____

Education and Training

College
Name: _____
Address: _____
City, State: _____
Dates Attended: _____ Major: _____ Degree: _____

Medical School
Name:_____Dates Attended: _____
Address: _____
City/State: _____

Internship
Name:_____Dates : _____
Address: _____
City/State: _____

Residency
Name:_____Dates : _____
Address: _____
City/State: _____

Fellowships, Other Special Training or Skills, Research Experience:_____
_____
_____
_____

Honors and Awards: _____
_____
_____

Medical Interests:_____
_____

Military Service

Were you in the U. S. Armed Forces? Yes _____ No _____ Branch_____

Dates of Duty: From _____To _____Rank/Grade _____

Medical Licensure: _____State(s): _____

Have you been or are you currently the subject of disciplinary proceedings by any state licensure agency? Yes ___ No ____

Have you been or are you currently the subject of disciplinary proceedings by any hospital? Yes ___ No ____

If you answered yes to either, please explain on an additional sheet and attach it to this application.

USMLE Step 1: Date _____Score _____

Step 2 CK: Date _____Score _____

Step 2 CS: Date _____Score _____

Step 3: Date _____Score _____

E.C.F.M.G. (if foreign trained): Number: _____Issue Date:_____

Members of Cincinnati Children's Hospital Medical Center Faculty, Attending Staff or House Staff known by the applicant:

_____

The following is required to support your fellowship application:

- Three letters of recommendation. One letter should be from the Director of your Residency Training Program.
- Current curriculum vitae.

Please contact the program directly for information about any additional requirements.

Optional: A recent photograph

I certify that the facts and information I have provided on this application, on other pre-employment documents and during interviews are true and complete; and I agree that, if I receive an appointment, incorrect, incomplete or falsified information will be grounds for dismissal, regardless of when discovered.

I understand that I must successfully complete a pre-employment physical evaluation conducted by Cincinnati Children's Hospital Medical Center at CCHMC's expense. Additional expenses related to specialized testing or follow-up by my private physician will be my responsibility.

I authorize Cincinnati Children's Hospital Medical Center to investigate all statements made herein or in my interviews and to obtain conviction records, make reference checks and obtain any other information relevant to my application; and I release Cincinnati Children's Hospital Medical Center and all other parties from any and all liability for any damages that may result from obtaining or furnishing such information.

I agree to observe all present and subsequently issued personnel policies and procedures of Cincinnati Children's Hospital Medical Center.

I understand that Cincinnati Children's Hospital Medical Center maintains a drug-free workplace as required by the Drug-Free Workplace Act of 1988. I agree to submit to a drug screen prior to beginning my appointment with Cincinnati Children's Hospital Medical Center. I understand that I will not be considered for an appointment at Cincinnati Children's Hospital Medical Center if I fail to consent to testing, fail to authorize release of results or tamper with the results in any way. I understand that the unlawful manufacture, distribution, sale, possession, or use of controlled substances or illegal drugs is prohibited on Cincinnati Children's Hospital Medical Center time and in and on property owned or controlled by Cincinnati Children's Hospital Medical Center.

I understand that I must obtain and maintain a valid permanent Ohio Medical License or an Ohio Medical Training Certificate before my first day of employment. Fees required to obtain the license or training certificate are my responsibility and not Cincinnati Children's Hospital Medical Center's. I understand that the institution's liability insurance is available for residents during their employment at CCHMC.

I understand that I must submit to and successfully complete a criminal records background check prior to employment at Cincinnati Children's Hospital Medical Center, in accordance with Ohio State Law.

I understand that in consideration of the hospital's patients, Cincinnati Children's Hospital Medical Center maintains a smoke-free workplace.

Signature: _____ *Date:* _____