Common Application for Clinical Fellowship Program Start Date 7/1/2013

PROGRAM: Pediatric & Adolescent Gynecology

All PAG fellowship programs will accept this common application. Please save a copy for your use.

GENERAL INFORMATION

NRMP #_____

Name: _____

Last *First* *Middle (complete)* *Maiden (if applicable)*

Present Address: _____ Telephone: (____) _____ Preferred

_____ Telephone: (____) _____ Alternate

E-mail address: _____ Pager Number _____

Date of Birth: _____ Citizenship Status: ☐ US Citizen ☐ US Permanent Resident ☐ J-1 visa ☐ H1-B Visa

☐Canadian Citizen ☐CDN Permanent Resident ☐ Other Nationality: Specify: _____

Are you eligible or authorized to work in the US? ☐ Yes ☐ No Social Security Number: _____

Are you able to practice in Canada? ☐ Yes ☐ No

Military Service

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

Dates of Duty: From _____To _____Rank/Grade _____

MEDICAL LICENSURE

State(s)/Province(s): _____Type:_____Expiration Date:_____

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 to this application.

BOARD ELIGIBILITY AND/OR CERTIFICATION

Are you US board certified? ☐ Yes ☐ No ABOG Certification date _____

If you are not yet certified, are you board eligible? ☐ Yes ☐ No If yes, when eligible? _____

Royal College of Physicians and Surgeons of Canada(FRCSC) Certification date _____

EDUCATION

Undergraduate

College/University: _____

City, State/Province if applicable and Country: _____

Dates Attended: _____ Major: _____ Degree:_____

Medical School:_____

City/State/Province if applicable and Country: _____

Dates Attended: _____ Degree: _____ Graduation Date:_____

E.C.F.M.G. (if foreign trained outside of US): Number: _____ Issue Date: _____

Note: You must provide a copy of your valid ECFMG certificate

TOEFL IBT (if foreign trained outside of Canada): Passing score: _____ *Note: Copy Must be provided*

CURRENT & PRIOR TRAINING

Internship

Institution:_____Dates: _____

Address/City/State or Province/Country: _____

Area of Training/Specialty: _____Completed Program? Yes ☐ No ☐

Residency

Institution:_____Dates: _____

Address/City/State or Province/Country: _____

Area of Training/Specialty: _____Completed Program? Yes ☐ No ☐

Fellowship

Institution:_____Dates: _____

Address/City/State or Province/Country: _____

Area of Training/Specialty: _____ Completed Program? Yes ☐ No ☐

EXPERIENCE

Organization & Location	Position	Dates

Other Special Training, Skills, or Research Experience:

AWARDS/ACCOMPLISHMENTS (you may expand on this section in your CV)

PUBLICATIONS & PRESENTATIONS (you may expand on this section in your CV)

The following documents are required to support your fellowship application:

- A minimum of three letters of recommendation. *One letter must be from the Director of your Residency Training Program*.
- Current *curriculum vitae*
- Copy of medical school diploma (with English translation if applicable)
- ECFMG certificate (if applicable)
- TOEFL IBT certificate (if applicable)
- Personal statement of career goals, with discussion of how you plan to use this training.

By my signature below, I certify that the information in this application is accurate.

Signature: _____ *Date:* _____

NOTE: Each PAG fellowship program has requirements in addition to this common application. To ensure that your application is complete, please contact the program to which you are applying for information about their specific institutional requirements. A list of PAG fellowship programs is available on the web at www.naspag.org/index.php/pagefellowships

Application for Clinical Fellowship

PROGRAM: Pediatric & Adolescent Gynecology

Jill Huppert, M.D., M.P.H., Program Director

Desired Start Date of Appointment: July 1, 2013

Cincinnati Children's Hospital Medical Center affords equal employment opportunity to qualified employees and applicants, regardless of their race, color, religion, sex, national origin, age, physical or mental disability, military or veteran status, sexual orientation, or other protected status in accordance with applicable federal, state, and local laws and regulations.

Applicant Acknowledgement and Authorization

I authorize Cincinnati Children's Hospital Medical Center (CCHMC) to investigate all statements made during my application process and to obtain conviction records, make employment reference checks, and obtain any other information CCHMC deems relevant to its hiring process. I fully release CCHMC (including its current or former officers, employees, agents, attorneys, and contractors) and all other related persons or entities from any and all liability for any damages that may result from obtaining or furnishing such information.

I understand and agree that, if hired; either I or CCHMC may end my employment at any time. I understand my employment is "at-will," and that no one may make any oral or written promises or agreements (except a writing signed by the CEO or his direct designee) which alter this employment-at-will relationship.

I agree to observe all present and subsequently-issued personnel policies and procedures. I understand that such policies and procedures do not constitute a contract of employment between me and CCHMC, and that CCHMC may revise its policies and procedures at any time.

I understand that CCHMC maintains a drug-free workplace in accordance with applicable provisions of the Drug-Free Workplace Act of 1988. I agree to submit to a drug screen prior to beginning employment with CCHMC; I understand that I will not be considered for employment 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 by CCHMC employees is prohibited, and that employees may not use prescribed medications that inhibit their abilities to perform their jobs.

I understand that in consideration of CCHMC's patients and applicable law, CCHMC maintains a smoke-free workplace.

I understand that CCHMC may require employees to work at other than their current assignments or schedules as needed.

I understand and agree that CCHMC pay distribution occurs through direct deposit to a banking institution designated by the employee.

By my signature below, I certify that I have read, fully understand, and accept all terms of the foregoing statement.

Signature: _____ *Date:* _____

DEADLINE for submission of application and all required documentation: July 15, 2012.
INTERVIEWS in Cincinnati will be scheduled August 30 and September 6, 2012.
DECISION will be announced in October, 2012.

Mail all required documents and completed application to:

Frances Saad, Program Coordinator
Division of Pediatric & Adolescent Gynecology
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, ML 2026
Cincinnati, OH 45229
P: 513-636-2911
F: 513-636-0166

Alternatively, a .pdf of the required documents can be emailed to:
Frances.Saad@cchmc.org