Application for Child & Adolescent Psychiatry Residency

Division: Child and Adolescent Psychiatry
Phone: (513) 636-7331 Fax: (513) 803-0571 Email: Kristin.Holhubner@cchmc.org

Mail completed application to: Cincinnati Children's Hospital Medical Center
Division of Psychiatry – College Hill Campus
5642 Hamilton Avenue
Cincinnati, OH 45224
ATTN: Kristin Holhubner

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___ PGY Level: _____

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

Present Address: _____ Telephone: ( ) _____
_____

Permanent Address: _____ Telephone: ( ) _____
_____

Email Address: _____ Pager: _____

Education and Training

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

Medical School
Name: _____ Dates Attended: _____
Address: _____
City, State: _____

Internship
Name: _____ Dates Attended: _____
Address: _____
City, State: _____

Residency
Name: _____ Dates Attended: _____
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: _____ States: _____

- 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.

Flex: _____ State: _____ Date: _____

National Board No: _____ Part I: _____ Date: _____ Score: _____

Part II: _____ Date: _____ Score: _____

Part III: _____ Date: _____ Score: _____

E.C.F.M.G. (If Foreign Trained): _____ No.: _____ Expiration 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 application:

- Three (3) letters of recommendation. One letter should be from the Director of your Residency Training Program.
- Current curriculum vitae.
- 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 the Expense of Cincinnati Children's. Additional expenses related to specialized testing or follow-up by my private physician will be my responsibility.

I authorize Cincinnati Children's 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 and all other parties form 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.

I understand that Cincinnati Children's 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. I understand that I will not be considered for an appointment at Cincinnati Children's if I fail to consent to testing, fail to authorize release of results or tamper with the results in any way. I understand the unlawful manufacture, distribution, sale, possession, or use of controlled substances or illegal drugs is prohibited on Cincinnati Children's time and in and on property owned or controlled by Cincinnati Children's.

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 the responsibility of Cincinnati Children's. I understand that the institution's liability insurance is available for residents during their employment at Cincinnati Children's.

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

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

Signature: _____ *Date:* _____