Application for Fellowship

Division: Adolescent Medicine
Phone: 513-636-2970 Fax: 513-636-7844 Email: michael.spigarelli@cchmc.org

Mail completed application to: Cincinnati Children's Hospital Medical Center
Attn: Michael Spigarelli, MD, PhD
Division of Adolescent Medicine
3333 Burnet Avenue
Cincinnati, OH 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: ( ) ___________________
____

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.

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 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 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 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.

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 that 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:* __________________________________