Application for Clinical Fellowship

PROGRAM: Neurology – Neurocritical Care and Cerebrovascular Fellowship

Desired Start Date of Appointment: _____

Email completed application to: Renee.Baker@cchmc.org

GENERAL INFORMATION

Name: _____
Last *First* *Middle (complete)* *Maiden (if applicable)*

Present Address: _____ Telephone: (____) _____ Preferred

_____ (____) _____ Alternate

E-mail address: _____ Pager Number: _____

Citizenship Status: ❒ US Citizen ❒ Permanent Resident ❒ J-1 visa ❒ H1-B Visa

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

Military Service
Were you in the U. S. Armed Forces? Yes _____ No _____ Branch _____
Dates of Duty: From _____ To _____ Rank/Grade _____

EXAMINATIONS

USMLE
Step 1: Date _____ Status _____
Step 2 CK: Date _____ Status _____
Step 2 CS: Date _____ Status _____
Step 3: Date _____ Status _____

OTHER Exam: _____ Date _____ Status _____
Exam: _____ Date _____ Status _____

MEDICAL LICENSURE

State(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 it to this application.

National Plan and Provider (NPI#): _____

EDUCATION

Undergraduate

College/University: _____

City, State: _____

Dates Attended: _____ Major: _____ Degree: _____

Medical School

School: _____

City/State: _____

Dates Attended: _____ Degree: _____ Graduation Date: _____

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

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

CURRENT & PRIOR TRAINING

Internship

Institution: _____ Dates: _____

Address/City/State: _____

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

Residency

Institution: _____ Dates: _____

Address/City/State: _____

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

Fellowship

Institution: _____ Dates: _____

Address/City/State: _____

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

EXPERIENCE

Organization & Location	Position	Dates

Other Special Training, Skills, or Research Experience: _____

AWARDS/ACCOMPLISHMENTS

PUBLICATIONS & PRESENTATIONS

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

The following documents are <u>required</u> to support your fellowship application:

- A minimum of two letters of recommendation. One letter should be from the Director of your Residency Training Program.
- Current curriculum vitae
- Copy of medical school diploma
- ECFMG certificate (if applicable)
- A recent photograph

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

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

Signature: _____ *Date:* _____

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Cincinnati Children's Hospital Medical Center
Division of Neurology – ML 2015
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J. Michael Taylor, MD
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