



# Application for Clinical Fellowship Radiology Department

PROGRAM: \_\_\_\_\_

Applying for which academic year? \_\_\_\_\_

## GENERAL INFORMATION

Name: \_\_\_\_\_  
*Last First Middle Maiden (if applicable)*

Present Address: \_\_\_\_\_

Cell Phone \_\_\_\_\_

Personal Email: \_\_\_\_\_ Country of Citizenship: \_\_\_\_\_

Visa Status/Type: Native Born US Citizen  Naturalized US Citizen  Permanent Resident  J-1 Visa  H1-B Visa

Are you eligible or authorized to work in the US? Yes  No

Focused second year pediatric imaging fellowship positions are also available. If you are interested in a second-year pediatric fellowship, please note potential interest in the following subspecialty area(s). Check all that apply.

General Pediatric Radiology  Neuroradiology  Trunk Imaging  Musculoskeletal Imaging

Pediatric Interventional Radiology  Clinical Informatics

Opportunities for additional training may also be available in Fetal Imaging, Cardiac Imaging, Ultrasound, and Fluoroscopy.

## EDUCATION – For all dates, use the "From MM/DD/YYYY to MM/DD/YYYY" format

**Undergraduate School Name** \_\_\_\_\_

Location (City, State & Country): \_\_\_\_\_

Start Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_ Degree/Concentration: \_\_\_\_\_

**Graduate/Medical School Name:** \_\_\_\_\_

Location (City, State, & Country): \_\_\_\_\_

Start Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_ Degree/Concentration \_\_\_\_\_

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

## CURRENT & PRIOR TRAINING – For all dates, use the "From MM/DD/YYYY to MM/DD/YYYY" format

**Internship:** \_\_\_\_\_  
*(Institution Name) (Dates: From – To)*

City, State & Country: \_\_\_\_\_

Area of Training/Specialty: \_\_\_\_\_ Completed Program? Yes  No

**Residency:** \_\_\_\_\_  
(Institution Name) (Dates: From -- To)

City, State, & Country: \_\_\_\_\_

Area of Training/Specialty: \_\_\_\_\_ Completed Program? Yes  No

**Fellowship:** \_\_\_\_\_  
(Institution Name) (Dates: From MM/DD/YYYY to MM/DD/YYYY)

City, State & Country: \_\_\_\_\_

Area of Training/Specialty: \_\_\_\_\_ Completed Program? Yes  No

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 question, please explain on a separate sheet and attach it to this application.*

## WORK/OTHER EXPERIENCE

Organization & Location	Position	Dates From MM/DD/YYYY – To MM/DD/YYYY

The following documents must accompany your fellowship application:

- Letters of Reference (three required, with one from your most current program director or direct supervisor).
- Personal Statement
- Current curriculum vitae
- Copy of medical/graduate school diploma (It must be in English or be a certified English translation)
- ECFMG certificate (if applicable)
- USMLE Transcripts (not score reports)
- A recent photograph, in JPEG format, clear and at least 300dpi

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: \_\_\_\_\_

*Please send completed applications and required documentation to:*

*Dr. Eric Crotty, MD, Program Director*      [Eric.Crotty@cchmc.org](mailto:Eric.Crotty@cchmc.org)

*Tosha Feldkamp, Program Coordinator*      [Tosha.Feldkamp@cchmc.org](mailto:Tosha.Feldkamp@cchmc.org)

*If sending application by mail, please send to:*

*Eric Crotty, MD; Program Director*

*c/o Tosha Feldkamp*

*Cincinnati Children's Hospital Medical Center*

*3333 Burnet Avenue, MLC #5031*

*Cincinnati, Ohio 45229-3039*

**02/15/2024**