Application for Child & Adolescent Psychiatry Residency

Name: _____ Date of Birth_____
Last *First* *Middle* *Maiden (if applicable)*

Present Address: _____ Telephone: _____
_____

Permanent Address: _____ Telephone: _____
_____

Email Address: _____ Pager: _____
Secondary Email Address: _____

Desired Start Date of Appointment: _____ Are you a U.S. Citizen? Yes___No___ If no, Visa type: _____
Are you eligible to work in the U.S.? Yes____No____ Current PGY Level: _____

Education and Training

Medical Education: _____
Address: _____
City *State* *Zip Code*
Dates Attended (m/d/yr.): _____ Degree: M.D.____ D.O._____ M.D./PhD_____

College: _____
Address: _____
City *State* *Zip Code*

Dates Attended: (m/d/yr.): _____ Major: _____ Degree: _____

Internship:
Name: _____ Dates Attended: _____
Address: _____
City *State* *Zip Code*

Residency:
Name: _____ Dates Attended: _____
Address: _____
City *State* *Zip Code*

Fellowships; Other Special Training or Skills:
_____
_____
_____
_____

Research Experience:
_____
_____
_____
_____
_____

Honors and Awards:
_____
_____
_____

Medical Interests:

_____

_____

Hobbies/Interests:

_____

_____

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 Score: ____ Date: _____ Step 2 Score: ____ CS: Pass/Fail ____ Date: _____ Step 3 Score: ___ Date: _____
COMLEX: Level 1 Score: _____ Date: _____ Level 2 Score: _____ Date: _____ Level 3 Score: _____ Date: _____
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 applicant:

_____

_____

The following is required to support your application:

- Three (3) letters of recommendation. One letter should be from your Residency Training Director and include the Training Director Form.
- Current curriculum vitae.
- A recent photograph
- Personal Statement
- Medical School diploma
- ECFMG certificate (if applicable)
- Medical School transcripts

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:* _____

Please mail completed application and required supporting documentation to:
Cincinnati Children's Hospital Medical Center, 5642 Hamilton Ave., Cincinnati, Ohio 45224 Attention: Kristin Holhubner
Phone: 513-636-7331 Fax: 513-803-0571