Application for Fellowship

Division: Developmental and Behavioral Pediatrics
Phone: 513-636-8375 Fax: 513-803-0072 Email: susan.wiley@cchmc.org

Mail completed application to: Susan Wiley, MD, Fellowship Program Director
Division of Developmental and Behavioral Pediatrics
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, MLC 4002
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:* _____