|  |  |  |
| --- | --- | --- |
| **A. DEMOGRAPHIC INFORMATION** | **Date:** |       |
| **1. Name** |       |       |       |
|  | *Last* | *First* | *Middle* |
|  |
| **2. Address** |        |       |       |       |       |
|  | *Street* | *City* | *State* | *Zip* | *Country* |
|  |
| **3. Phone** |       |       |  | **4.**  |       |
|  | *Day* | *Evening* |  |  | *Current PGY Level* |
|  |
| **5.**  |       |
|  | *Email* |
|  |
| **B. COLLEGE AND MEDICAL SCHOOL EDUCATION** |
| **1.**  |       |       |       |
|  | *Institution* | *Degree* | *Date* |
|  |
| **2.**  |       |       |       |
|  | *Institution* | *Degree* | *Date* |
|  |
| **3.**  |       |       |       |
|  | *Institution* | *Degree* | *Date* |
|  |
| **C. REFERENCES** |
| **1.**  |       |       |       |
|  | *Name* | *Phone* | *Email* |
|  |  |  |  |
| **2.**  |       |       |       |
|  | *Name* | *Phone* | *Email* |
|  |  |  |  |
| **3.**  |       |       |       |
|  | *Name* | *Phone* | *Email* |
|  |
| **D. HOSPITAL AND CLINICAL EXPERIENCE (PGY-2 and PGY-3 Applicants)** |
| **1.**  |       |       |       |       |
|  | *Institution* | *Position (PGY Level)* | *From (date)* | *To (date)* |
|  |  |  |  |  |  |  |  |  |  |
| **2.**  |       |       |       |       |
|  | *Institution* | *Position (PGY Level)* | *From (date)* | *To (date)* |
|  |  |  |  |  |  |  |  |  |  |
| **3.**  |       |       |       |       |
|  | *Institution* | *Position (PGY Level)* | *From (date)* | *To (date)* |
|  |
| **E. LICENSURE** |
| **1.**  |       |  | **2.**  |       |  | **3. Type** | Permanent | **[ ]**  |
|  | *State* |  |  | *Number* |  |  | Limited | **[ ]**  |
|  |  |  |  |  |  | None | **[ ]**  |
|  |
| **4.**  |       |  | **5.**  |       |
|  | *Sponsoring Hospital* |  |  | *Expiration Date* |
|  |
| **6.**  | **Educational Council for Foreign Medical Graduates** |
|  | *Graduates of medical schools outside the US and Canada who will treat patients are required to be ECFMG certified. If you are certified, please enclose a photocopy of your standard certificate.* |
|  |       |  |       |
|  | *Certificate number* |  | *Date of exam* |
| *All physicians must hold a Massachusetts medical license to treat patients at Children’s Hospital.* |
| **F. CITIZENSHIP** |
| **1. Are you a US citizen?** | Yes | **[ ]**  |  | **2. Do you have a US visa?** | Yes, type:       |
|  | No | **[ ]**  |  |  | No | **[ ]**  |
|  |  |  |  |  | N/A | **[ ]**  |
|  |
| **3. What type of visa will you hold while at BCH?** |       |  |
|  |
| **4. Are you in the US on an Exchange Visitor program?**  | Yes, sponsor: |       |
| *If yes, please give the name and program number of your present sponsor.*  | No | **[ ]**  |
| N/A | **[ ]**  |
|  |  |  |

To submit your application for consideration, please mail this completed application along with the following items to:

1. Three letters of recommendation: one from each of your references listed on this application

2. One letter of recommendation from medical school Dean

3. Medical school transcripts

4. A list of publications (optional)

5. Photograph (optional)

Attn: Program Director, Pediatric Nephrology Fellowship Program

Boston Children’s Hospital

Division of Nephrology

300 Longwood Ave

Boston, MA 02115

Please direct any questions to Division of Nephrology.

Phone: 1-617-355-6129

Fax: 1-617-730-0569