

### Checklist for Submission:

- Email the following forms directly to the Fellowship Program Coordinator, Sarah Gioia at [sgioia@luriechildrens.org](mailto:sgioia@luriechildrens.org)
  - Completed application form
  - Personal Statement
  - Updated CV
  - Photocopies of the following documentation:
    - USMLE Scores with dates
    - ECFMG Certificate if applicable
    - TOEFL Scores if applicable
  
- Have three (3) letters of recommendation sent directly by letter-writer to the Fellowship Program Coordinator, Sarah Gioia at [sgioia@luriechildrens.org](mailto:sgioia@luriechildrens.org)
  - Fill out the Confidential Reference Report for each of your recommenders and have the letter-writers submit a Confidential Reference Report along with each letter of recommendation – See Appendix B
  - If a current resident, one letter must be from your current Program Director.

**Pediatric Health Services and Population Health Research  
Fellowship Program Application**

For the 2020 Fall Pediatric Subspecialty Fellows start date of July 1, 2021

Note: Photocopy the completed application for your files. Please notify Sarah Gioia at [sgioia@luriechildrens.org](mailto:sgioia@luriechildrens.org) of any change in your address or phone number.

**Profile**

First Name:	
Middle Name:	
Last Name:	
Suffix:	
Previous Last Name:	
Contact Email:	
Date of Birth:	
International applicants, specify type of visa you hold	
Phone:	
Emergency Contact (Name and Number):	

Temporary Mailing Address	
Street Address:	
City:	
State/Province:	
Zip/Postal Code:	
Mailing address current until:	

Permanent Mailing Address	
Street Address:	
City:	
State/Province:	
Zip/Postal Code:	

### Citizenship

- US Citizen
- US Permanent Resident
- Other (Please list):

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If you are a foreign national outside the US, or currently in the US on a valid visa status, please **note the programs that accept Visa applicants and respond to the questions below.** IF NOT A FOREIGN NATIONAL, SKIP TO THE SECTION LABELED “EDUCATION SECTION: General educational information” below the ECFMG/TOEFL scores.

Will you need a “visa sponsorship” through the teaching hospital (J1, H1B, etc.) to participate in US fellowship training?  Yes  No

If yes to above:

- Please specify type of Visa:

- Did you train at a foreign medical school?  Yes  No
- Is your medical school listed on the approved list for state licenses to which you will be applying?  Yes  No  Unsure\*

International medical students only		
ECFMG Certificate	Date Issued	No.
TOEFL SCORES	Date Issued	Score

*\*If you are unsure, please contact the programs to which you are applying. Obtaining state license, for the state in which you will be training, is mandatory to being fellowship.*

EDUCATION SECTION: General Education Information					
College/University		From:		To:	
City, State:		Degree:			
Medical School:		From:		To:	
City, State:		Degree:			
Internship:		From:		To:	
City, State:		Degree:			
Residency:		From:		To:	
City, State:		Degree:			
Other Training:		From:		To:	
City, State:		Degree:			

Was your medical education/training extended or interrupted?  Yes  No

If yes, please note the date and comment:

<b>Other Medical Experience (Include experience such as private practice, hospital and staff appointments, research and military)</b>		
Type	Location	Dates
Type	Location	Dates
Type	Location	Dates
Type	Location	Dates

<b>Examinations Taken (photocopies of original documents with scores and dates must accompany the application)</b>			
<b>U.S./Canadian/International medical school graduates</b>			
USMLE	Step 1	Step 2	Step 3
First time pass?	Y / N	Y / N	Y / N

<b>Licensure Information</b> This section allows entries for each of your state medical licenses.			
<b>Entry 1</b>			
State:		License Number:	
License Type:		Expiration Month/Year:	
<b>Entry 2</b>			
State:		License Number:	
License Type:		Expiration Month/Year:	
<b>DEA Number</b> (DEA is for US Medical License holders only.)			
DEA Registration Number		Expiration Month/Year:	

No current medical license (If you do not have a current medical license, skip to the “Board Certification” questions.)

1. Has your medical license ever been suspended / revoked / voluntarily terminated?

Yes  No

If yes, please note the date and comment:

2. Have you ever been named in a malpractice case?  Yes  No

If yes, please note the date and comment:

3. Is there anything in your past history that would limit your ability to be licensed or would limit your ability to receive hospital privileges?

### Board Certification

Are you Board Certified?  Yes  No

If no, will you be Board Eligible by the beginning of the fellowship?  Yes  No

Board Name:

Are you Board Certified/eligible for more than one Board?  Yes  No

If no, will you be Board Eligible by the beginning of the fellowship?  Yes  No

Board Name:

### Miscellaneous

Are you able to carry out the responsibilities of a fellow in Academic General Pediatrics and at the specific training program to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations?  Yes  No

If no, please comment:



### Letters of Recommendation

Please provide three letters of recommendation. **If within 5 years of residency training, one of these letters must be from your residency program director or his or her designee.** Your letter writers can send their letters directly by e-mail to the Program Director at the address listed below in the Appendix. Please fill out the Confidential Reference Report for each of your recommenders and submit a Confidential Reference Report along with each letter of recommendation.

#### Reference 1

Name:	
Contact Information:	

#### Reference 2

Name:	
Contact Information:	

#### Reference 3

Name:	
Contact Information:	

### **Personal Statement**

Please attach personal statement explaining why you want to do a fellowship in Academic General Pediatrics and/or Primary Care. Please include a description of your career goals, how the fellowship may assist you in achieving them, your scholarly/research interests, and how you envision your career five years after completion of this fellowship. You may want to include how past experiences have influenced your decision to apply and mention special areas of interest. *(Make sure your name appears on the attachment.)*

### **Attestation**

I certify that the information contained in this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; or if employed, may constitute cause for termination from the program. I also understand and agree that the data included in this application may be shared within the fellowship programs to which I am applying.

I agree with the attestation.

Date: \_\_\_\_\_

## Appendix A: Supplemental Biographical Information

The information requested is for statistical purposes only and will not be used during consideration of the application.

Date of Birth:	
Place of Birth:	
Gender:	
<p>Ethnicity/Race (Self-identification):</p> <p>Ethnicity</p> <p><input type="checkbox"/> Of Hispanic or Latino origin (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race).</p> <p><input type="checkbox"/> Not of Hispanic or Latino origin</p> <p>Race</p> <p><input type="checkbox"/> Black or African American: A person having origins in any of the original groups of Africa.</p> <p><input type="checkbox"/> Asian or Asian-American: Includes persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent (e.g. Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).</p> <p><input type="checkbox"/> American Indian or Alaskan native: Includes persons having origins in any of the original peoples of North America and South American (including Central America), who maintains tribal affiliation or community attachment.</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.</p> <p><input type="checkbox"/> White: Includes persons having origins in any of the original peoples of Europe, North Africa or the Middle East.</p>	
<p>Disadvantaged Background:</p> <p>An individual from a disadvantaged background is defined as someone who: Comes from an environment that has inhibited the individual from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school, or from a program providing education or training in an allied health profession. OR Comes from a family with an annual income below a level based on low-income thresholds according to family size published by the U.S. Bureau of the Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary of Health and Human Services for use in health professions and nursing programs.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

## Appendix B

### CONFIDENTIAL REFERENCE REPORT

**TO THE APPLICANT:** You need three of these forms for your three references. Please see instructions on the form.

Applicant's Name: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_  
\_\_\_\_\_

Applicant's Telephone Number: \_\_\_\_\_

### **TO THE REFERENCE:**

The candidate whose name appears above considers you able to assess his/her qualifications as a fellow candidate for the Academic General Pediatric/Primary Care Fellowship Program. The program provides training opportunities to physicians who have completed their residencies and aspire to faculty positions. Formal training in teaching methodologies, epidemiology, also statistics, computers and health care research will be offered. Each fellow must design, implement and analyze a research project and will be directly involved in health care delivery and medical and graduate medical education.

<b>INSTRUCTIONS:</b>		Unable To Judge	Poor Lowest 25%	Fair Middle 26%-75%	Excellent Top 76%-90%	Outstanding Top 91%-100%
<p>(1.) Please complete the chart on the right. Rate the applicant by writing the number which most nearly represents your opinion of the applicant in comparison with a representative group of individuals you have known who have had approximately the same training and experience.</p> <p>(2.) In an accompanying letter, please elaborate on the applicant's performance on the basis of which you arrived at your assessment, citing, if possible, specific illustrations. In addition, indicate the candidate's points of greatest strength and weakness and comment on his/her personal and professional qualifications for a career in academic pediatrics.</p> <p><b><u>This Form Will Not Be Reviewed Without The Accompanying Letter</u></b></p> <p><b>(3) DO NOT RETURN THE COMPLETED FORM TO THE APPLICANT. PLEASE MAIL DIRECTLY WITH YOUR LETTER TO THE PROGRAM:</b></p>		<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
	Initiative					
	Ability to meet deadlines					
	Clinical ability					
	Interpersonal facility with peers					
	Potential skill at research					
	Clinical judgment/critical sense					
	Academic performance					
	Leadership capacity					
	Ability to function in a stressful environment					
	Ability to communicate (Written)					
	Ability to communicate (Spoken)					
	Teaching ability					
	Overall evaluation					

\_\_\_\_\_  
Signature of person providing reference

\_\_\_\_\_  
Printed name of person providing reference

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title of person providing reference

\_\_\_\_\_  
Institution

\_\_\_\_\_  
Telephone Number