Children's Hospital Department of Pathology

300 Longwood Avenue, Boston, Massachusetts 02115 (617) 355-7431

PRELIMINARY APPLICATION FOR HOUSE STAFF

Service _____ Date available for Appointment _____
Title of Appointment _____ PG Level (if applicable) _____
Name _____ Social Security No. _____
FIRST MIDDLE LAST (Family Name)
Present Address _____
Telephone Number _____
Permanent Address _____

LICENSURE
Massachusetts ___Permanent Number _____
___Limited _____ Sponsoring Hospital _____
___None

Other (state where) _____

IF YOU ARE NOT A CITIZEN OF THE UNITED STATES:

What type of Visa will you hold while at Children's? _____

If you are in the United States on an Exchange Visitor Program, give the name and program number of your present sponsor.
_____

If you are living outside of the United States and contemplate entry as an exchange visitor, complete below:

___Male ___Female ___Single ___Married ___Widowed ___Divorced ___Separated

Date of Birth _____ Country of Birth _____
MONTH DAY YEAR

Place of Birth _____ Country of Citizenship _____
CITY and STATE or PROVINCE

Full name of wife or husband _____
Have you previously been in the United States as an exchange visitor? ___Yes ___No
If EV is to be accompanied by dependents, list on a separate sheet names, relationships, dates and places of birth, and nationalities for each family member.

A graduate of a foreign medical school (except Canada) who will have any clinical responsibilities is required to be certified by the Educational Council for Foreign Medical Graduates (ECFMG).

If you are certified, indicate below:
Standard Certificate: Number _____ (photocopy must be enclosed)
Interim Certificate: Number _____ (photocopy must be enclosed)
Date of Passing ECFMG Exam: _____

Have you taken and passed the Visa Qualifying Examination (VQE)? ___Yes ___No

COLLEGE AND MEDICAL SCHOOL EDUCATION

INSTITUTION	DEGREE	DATE

HOSPITAL AND CLINICAL EXPERIENCE
(If internship, be specific as to type, i.e., rotation, medical, pediatric, surgical, etc.)

INSTITUTION	POSITION (PG Level if applicable)	FROM	TO

If you are the recipient of a fellowship, stipend, or other professional grant, give name of donor:

Donor Name _____ Duration -- From _____ To _____

Amount of Support provided _____ Has the amount actually been awarded? ___Yes ___ No

Membership in Societies

REFERENCES:
(Full address, telephone, and fax number with each. Please have two references write directly to the Director of Training Program.)

Please arrange for your medical school to send a transcript of record, standing in class, and recommendation to the Director of Training Program.

Attach in duplicate Research and Publications

SIGNATURE OF APPLICANT _____ DATE _____