

THE CHILDREN'S HOSPITAL • BOSTON

300 Longwood Avenue, Boston, Massachusetts 02115

Application for Housestaff (Internship/Residency)

Department of Pediatrics

Name _____			PL Level _____	for 19 _____
last	first	middle		
Present Address _____				
Present Phone Numbers: Day () _____			Evening () _____	
Permanent Address _____				
Social Security Number _____/_____/_____			Participating in Match ____ Yes ____ No	
Optional: _____				
Date of Birth			Birthplace	

COLLEGE AND MEDICAL SCHOOL EDUCATION

INSTITUTION	DEGREE	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

REFERENCES

Full address with each - Please have two references write directly to the Chief of the Department of Pediatrics and arrange for your medical school to send a transcript of record and dean's letter. A list of publications, personal statement and photograph are optional.

HOSPITAL AND CLINICAL EXPERIENCE (PL-2 and PL-3 Applicants)

INSTITUTION	POSITION (PL Level)	FROM	TO
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LICENSURE

Massachusetts:

Permanent Number: _____

None

Limited

Sponsoring Hospital: _____

Date of Expiration: _____

Other (state where) _____

All physicians must hold a Massachusetts medical license in order to treat patients at Children's Hospital.

IF YOU ARE NOT A CITIZEN OF THE UNITED STATES

Do you currently hold a visa for the U.S.? If yes, describe: _____

What type of visa will you hold while you are at CH? _____

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

If you are living outside of the U.S. 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 _____

Full name of spouse _____

Have you previously been in the U.S. as an exchange visitor? Yes No

Will dependents accompany you? Yes No Will dependents travel with you? Yes No

List on a separate sheet: Names, relationships, ages and places of birth, and nationalities for each family member.

A graduate of a foreign medical school (except Canada) who will treat patients is required to be certified by the Educational Council for Foreign Medical Graduates (ECFMG). If you are certified, please 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

Have you taken and passed the Foreign Medical Graduate Exam in the Medical Sciences (FMGEMS)?

Yes No (first FMGEMS 7/24/84)

Signature of Applicant

Date