Fellowship Application

Children's Hospital Boston
Anesthesia Department, Bader 3
300 Longwood Avenue
Boston, MA 02115-5737

Name:_____
Last First Middle

Address:_____
Street City State Country Zip Code

Daytime Telephone: (___) _____

Home Telephone: (___) _____

E-mail Address:_____

Place of Birth:_____
City State or Province Country

Country of Citizenship:_____

If NOT a U.S. Citizen, ECFMG Certification? ☐ No ☐ Yes (Please provide photocopy)

Date of Certificate_____ Number_____

Please indicate type of Visa to be held while at Children's Hospital:_____

Medical Licensure: Please list all licenses held.
Massachusetts: ☐ None

☐ Limited License: Sponsoring Institution:_____

Date of Expiration:_____

☐ Permanent License:_____
Number Date of Licensure Date of Expiration

Other States: _____
State Number Date of Licensure Date of Expiration

_____
State Number Date of Licensure Date of Expiration

_____
State Number Date of Licensure Date of Expiration

Examinations:
Please enter your scores for USMLE Steps 1, 2 and 3 or COMLEX Parts 1, 2 and 3, and completed In-Training Exams (CA-2 In-Training Exam scores should be submitted when received) as applicable.

☐ None

Entry 1:
Exam:_____

Month:_____ Year_____

Score:_____ ☐ Pass ☐ Fail ☐ N/A

Entry 2:
Exam:_____

Month:_____ Year_____

Score:_____ ☐ Pass ☐ Fail ☐ N/A

Entry 3:
Exam:_____

Month:_____ Year_____

Score:_____ ☐ Pass ☐ Fail ☐ N/A

Entry 4:
Exam:_____

Month:_____ Year_____

Score:_____ ☐ Pass ☐ Fail ☐ N/A

Please indicate type of fellowship sought:

Pediatric Anesthesiology.....☐ 1 year ☐ 2 years
Application and letters of recommendation to Mary Landrigan-Ossar, M.D., PhD
c/o Molly Langston
Cardiac Anesthesiology (1 year).....
Application and letters of recommendation to James A. DiNardo, M.D.
Pediatric Pain Management (1 year).....
Application and letters of recommendation to Christine D. Greco, M.D.

Preferred date for beginning fellowship:_____ PGY at that date:_____

Please list all educational, clinical and research appointments, beginning with your college education. **Please explain any gaps,** using a separate sheet if necessary.

FROM month/year	TO month/year	INSTITUTION	POSITION or DEGREE EARNED

Gaps in training:

_____
_____
_____
_____

Miscellaneous:

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

☐ Yes ☐ No

Reason:

_____
_____
_____

Have you ever been named in a malpractice case?

☐ Yes ☐ No

Reason:

_____
_____
_____

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?
☐ Yes ☐ No
Reason:

_____
_____
_____

Have you ever been convicted of a felony?
☐ Yes ☐ No
Reason:

_____
_____
_____

Recommendations:
Please list the names of three people who will write letters of reference on your behalf, indicating the Department Chairman or Program Director (required) by an asterisk(*):

_____
Name Title

_____
Name Title

_____
Name Title

Please include a current copy of your *Curriculum Vitae* and USMLE/COMLEX/ITE score transcripts (copies acceptable). Score transcripts may be submitted after your application has been submitted, but must be received in order for your application to be completed.

Signature_____ Date_____