



Hospital and Clinical Experience

Institution

Position (PGY Level)

From

To

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Licensure

Massachusetts: \_\_\_\_\_ Permanent Number: \_\_\_\_\_  
\_\_\_\_\_ None \_\_\_\_\_ Limited Sponsoring Hospital: \_\_\_\_\_  
Date of Expiration: \_\_\_\_\_

Other (provide location): \_\_\_\_\_

\*All physicians must hold a Massachusetts medical license in order to treat patients at Boston 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 BCH? \_\_\_\_\_

If you are currently in the U.S. on an Exchange Visitor Program, please 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

Date of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_

Place of Birth \_\_\_\_\_ Country of Citizenship \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

To be completed by reviewer only:

	Documents	✓
1.	Completed application	
2.	3 Letters of recommendation	
3.	CV (Month and Year format)	
4.	USMLE/ECFMG score sheets	
5.	Personal Statement	
6.	Medical School Transcript	
7.	Dean's Letter	
8.	Photograph	