

The Children's Hospital of Philadelphia

Office of Graduate Medical Education / Department of Medical Staff Affairs

The Children's Hospital of Philadelphia

34th Street and Civic Center Boulevard

Philadelphia, PA 19104

Telephone: 215-590-1190 / 215-590-4671 Fax: 215-590-2204

APPLICATION FOR INCOMING CLINICAL ROTATION for FISCAL YEAR 2010

I hereby apply for appointment as a Rotating Graduate Medical Trainee at The Children's Hospital of Philadelphia in the Division of _____ Program of _____
 from _____ to _____
 Start date (MM/DD/YYYY) End Date (MM/DD/YYYY)

Trainee Demographic Information:

First Name:	
Last Name:	
Degree(s):	
Home Mailing Address:	
City, State and Zip Code:	
Home Phone:	
Cell Phone:	
Email:	
Date of Birth:	
Place of Birth – City, State, Country:	
Citizenship:	
Visa Type (if applicable) <i>Attach copy</i>	
Social Security Number: (Mandatory)	
NPI #:	

Current Training Program Information:

Hospital (Employer):	
Mailing Address:	
City, State, Zip code:	
Program Director:	
Program Coordinator:	
Program Coordinator's Phone Number:	
Program Coordinator's Email Address:	

Board Certification Information:

Program for which you are CURRENTLY working on for Board Certification	
Program for which you INITIALLY sought Board Certification (If different from current program)	

Pennsylvania Licensing Information:

Do you currently hold a training license in Pennsylvania? (yes or no):	
If yes, note license number and attach copy:	
Have you EVER held a training license in Pennsylvania? (yes or no):	
Do you currently hold an unrestricted license to practice medicine in Pennsylvania? (yes or no):	
If yes, note license number and attach copy:	

Medical Education:

College / University (including Campus)	Degree	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Are you a graduate of a foreign medical school? (yes or no):	
If yes, attach copy of certificate and:	
<ul style="list-style-type: none"> • note current ECFMG Certification number: 	
<ul style="list-style-type: none"> • note ECFMG Certification issue date (MM/DD/YYYY): 	

Residency / Fellowship Training (list all programs in which you have trained):

Hospital Name	City/State	Specialty	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Certification by Trainee:

I certify that this Application, including all attachments and supplemental information, is true and correct to the best of my knowledge. I attest to the correctness and completeness of all information furnished. I fully understand that any significant misstatement or omission from this Application constitutes cause for denial of or dismissal from this educational opportunity. I authorize a representative of The Children's Hospital of Philadelphia to consult anyone who may have information bearing on my competence, ethics, character and other qualifications. I consent to the inspection, copying and release of all records and documents that may be material to evaluation of my competence, ethics, character and other qualifications. I release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information in good faith regarding my competence, ethics, character, and other qualifications, including otherwise confidential information.

Signature

Date

Certification by Program Director or Director of Medical Education:

I certify that Dr. _____ (trainee) is in good academic standing in the _____ training program currently accredited by the

ACGME or AOA (check one) , and our Office of Graduate Medical Education has verified his/her qualifying credentials in accordance with Joint Commission standards and ACGME / AOA program requirements as well as the following items:

- Verification that full coverage of salary, benefits and professional liability insurance is to be provided by the parent/sponsoring institution unless there is a fully executed written agreement to the contrary.;*
- Verification of training with respect to the HIPAA standards at the parent/sponsoring institution;*
- Verification of compliance with all health/immunization requirements of parent/sponsoring institution;*
- Verification of a satisfactory criminal background check completed by parent/sponsoring institution within 3 years of rotation dates; and,*
- Verification of current BLS certification; and, for rotators to Anesthesia, current ALS certification.*

I also certify that I have reviewed this application in its entirety for accuracy and completeness. It is understood that this information will be used for The Children's Hospital of Philadelphia's application for funds under the Children's Hospital Graduate Medical Education Payment Program.

Signature

Date

Printed Name

Title

**Return To: Anne Marie Krause, Manager
Department of Medical Staff Affairs
Office of Graduate Medical Education
The Children's Hospital of Philadelphia
3535 Market Street
12th Floor, Suite 1220
Philadelphia, PA 19104**