

***A SMALL PHOTOGRAPH MUST ACCOMPANY THIS INFORMATION SHEET**

APPLICATION FOR FELLOWSHIP TRAINING

The Children's Hospital
University of Colorado Health Sciences Center Affiliated Program
13123 East 16th Avenue
Aurora, Colorado 80045

Subspecialty Interest: _____ Date of Desired Appt. _____

Full Name: _____ Day Phone #: _____

Current Address: _____ Evening Phone #: _____

Permanent Address (if different): _____ Social Security #: _____

U.S. Citizen: Yes No Visa Status _____ (If you are not a US citizen, please indicate your visa status.)

Foreign medical school graduates (except Canada) who will have clinical responsibilities are required to be certified by the Educational Council for Foreign Medical Graduates (ECFMG). Indicate the date you passed the ECFMG exam and attach certificate.

Military status: _____ Do you speak a second language? (specify): _____

Pre-Medical Education: Give names of schools, addresses, dates of attendance and degrees.

Medical Education: Give names of schools, addresses, dates of attendance and degrees.

Residency Training: Give name of hospital, address, type of program and dates.

List all activities since medical school graduation in chronological order, including sabbaticals and non-medical activity. Please leave no time gaps.

Board Certification: _____ Certificate #: _____ Date: _____

Please enclose a photocopy of the certificate. If you are not certified, have you applied to take the exam? _____

Medical and Professional Associations: _____

Special Training Not Listed Above: (assistantships, practice, etc.):

Licensed to practice in which states: _____

Publications and Research (attach duplicate): _____

FELLOWSHIP APPLICATION
PAGE TWO

Please answer the following. If the answer to any question is YES, you must attach a letter explaining the circumstances. With regard to legal action, describe the events which gave rise to the case, the parties involved, the status and merits of the case and outcome, if any.

Health Status

1. Date of last complete physical examination. _____
2. Present health status: Good _____ Fair _____ Poor _____ (If fair or poor, state reasons on separate sheet.)
3. Have you been hospitalized in the past five years? YES _____ NO _____
4. Have you been denied health, life, or disability insurance? YES _____ NO _____
5. Do you have any limitations on your health, life, or disability insurance? YES _____ NO _____
6. Have you had any problems with alcohol or drug dependency? YES _____ NO _____
7. Are you currently taking medication that may affect either you clinical judgement or motor skills? YES _____ NO _____
8. Are you currently under any limitations, in terms of activity or work load? YES _____ NO _____
9. Are you currently under the care of a physician for any significant, acute, or chronic disorder? YES _____ NO _____
10. Do you have any physical or mental impairment which affects your ability to practice medicine? YES _____ NO _____

Professional Information

1. Has your license been denied, limited, suspended, or revoked in any state? YES _____ NO _____
2. Has any formal complaint been filed against you in any state which may result or has resulted in probation, revocation, or suspension of your license? YES _____ NO _____
3. Has your employment or privileges at any hospital been denied, reduced, suspended, terminated or put on probation or have you resigned while under investigation related to possible incompetence or improper professional conduct? YES _____ NO _____
4. Have proceedings been initiated which may result in probation, reduction, or suspension of you privileges at any hospital? YES _____ NO _____
5. Has your membership in any professional or medical societies ever been terminated? YES _____ NO _____
6. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program? YES _____ NO _____
7. Have you ever been or are you now the subject of investigation by any private, federal, or state agency concerning you participation in any private, federal, or state health insurance program? YES _____ NO _____
8. Has your narcotics registration certificate ever been denied, limited, suspended, or revoked? YES _____ NO _____
9. Is your narcotics registration certificate currently being challenged? YES _____ NO _____

Legal Actions

1. Have you ever been named as a defendant in any criminal proceeding? YES _____ NO _____
2. Have you been convicted of or entered a guilty or nolo contendere plea to a felony? YES _____ NO _____
3. Have any professional liability suits been filed against you? YES _____ NO _____
4. Have any professional liability suits been filed against you which are presently pending? YES _____ NO _____
5. Have any judgements or settlements been made against you in professional liability cases? YES _____ NO _____
6. Are there circumstances that would prevent you from fulfilling a fellow's responsibilities of working nights, holidays, or weekends? YES _____ NO _____

Names and addresses of at least three medical professionals whom you wish to use as references. These letters should be sent directly to the interviewing department/section as soon as possible after the submission of this application.

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

Donor name: _____ Duration: _____ Amount: _____

I certify that the statements contained in the application form are true and complete. I understand that this information will be verified and that any omission or distortions will significantly prejudice my application. I authorize the appropriate administrative official of The Children's Hospital or University of Colorado Health Sciences Center (TCH/UCHSC) to make inquiries and investigations necessary to establish my professional qualifications, my adherence to the ethics of my profession, my good reputation, and ability to work with others. I also authorize any person, hospital, or health care facility to whom TCH/UCHSC makes appropriate inquiries, to disclose to TCH/UCHSC all information and facts known or believed by them, related to my professional qualifications. As a condition of this application, I hereby release all the above parties from any liability for such inquiries and disclosures relating to my professional qualifications.

Signature: _____ Date: _____