

APPLICATION FOR PEDIATRIC CRITICAL CARE FELLOWSHIP TRAINING
THE CHILDREN'S HOSPITAL/ UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER
13121 East 17th Avenue, P.O. Box 6508
Aurora, Colorado 80045

First name: _____ Last name: _____ Social security #: _____
Daytime phone: _____ Evening phone: _____ Desired start date: _____
E-mail address: _____
Current address: _____
Permanent address (if different from above): _____

Citizenship: _____ If you are not a US citizen, indicate your visa status: _____
Foreign medical school graduates (except Canadian) who will have clinical responsibilities must be certified by the Educational Council for Foreign Medical Graduates (ECFMG). Indicate the dates you have passed the ECFMG exam and attach a copy of your current certificate. The University of Colorado only sponsors J-1 clinical visas. If accepted into our program, you must hold a valid J-1 clinical visa throughout your training.

Military status: _____ Do you speak a second language?: _____

Pre-medical education: (give names of schools, addresses, dates of attendance, and degrees obtained)

Medical education: (give names of schools, addresses, dates of attendance, and degrees obtained)

Residency training: (give names of hospitals, address, type of program, and dates of training)

List all activities since medical school graduation in chronological order, including sabbaticals and non-medical activity. Please do not leave any time gaps.

Board certification: ABP #: _____ Date: _____

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

Special training not listed above:

List those states in which you have a license to practice medicine: _____

Letters of reference should be sent directly to the program director as soon as possible after submission of this application.

1. _____
2. _____
3. _____

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

Health status

Date of last complete physical examination:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Present health status: Excellent (if poor, state reasons on a separate sheet)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been hospitalized in the past 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been denied health, life or disability insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any limitations on your health, life, or disability insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any problems with alcohol or drug dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently taking medications that may affect either your clinical judgment or your motor skills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently under any limitations in terms of activity or workload?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently under the care of a physician for any significant acute or chronic disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any physical or mental impairment that affects your ability to practice medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Professional information

Has your license been denied, limited, suspended, or revoked in any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any formal complaint been filed against you in any state that may result or has resulted in probation, revocation, or suspension of your license?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have proceedings been initiated which may result in probation, reduction, or suspension of your privileges at any hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your membership in any professional or medical society ever been terminated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been or are you now the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your narcotics registration certificate ever been denied, limited, suspended, or evoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your narcotics registration certificate currently being challenged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Legal Actions:

Have you ever been named as a defendant in any criminal proceeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been convicted of or entered a guilty or nolo contendere plea to a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have any professional liability suits been filed against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have any professional liability suits been filed against you that are presently pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have any judgments or settlements been made against you in a professional liability case?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there circumstances that would prevent you from fulfilling a fellow's responsibilities of working nights, weekends, and holidays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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 omissions or distortions will significantly prejudice my application. I authorize the appropriate administrative officials of The Children's Hospital or The 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 my ability to work with others. I also authorize any person, hospital, or health care facility to which 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: _____