Pediatric Neuroradiology Fellowship Application

Nemours Children's Hospital

Pediatric Neuroradiology

6535 Nemours Parkway, Orlando FL 32827

Name: _____
Last/Surname First Middle

Present Home Address: _____
Street Address

_____
City State Zip Code Country

Telephone (include country code): _____
Home/Mobile Work

E-mail: _____ Fax (if available): _____

Medical School: _____
Institution Location Degree & Date Conferred

Residencies/Fellowships: _____
(use additional pages if necessary) Institution Location Dates

Current Position: _____
Institution Location Dates

Citizenship: ☐ U.S. ☐ Other (specify): _____ VISA/Status: _____

Will you need "visa sponsorship" through ECFMG or the teaching hospital to participate in U.S. residency training? Select one:

☐ Yes, please select one ☐ H1-B ☐ J-1 ☐ No ☐ Uncertain ☐ Other: _____

Fellowship Duration

Length of Fellowship: 1 Year

Supporting Documents

Please include the following with your completed application:

- Medical School Diploma
- Board Certification
- Curriculum Vitae (include current work status)
- USMLE Scores or Canadian Equivalent (if applicable)
- Recommendation Letters (3) - must be on official letterhead
- Residency Certificate
- Copy of ECFMG Certification (if applicable)
- DEA Registration Number if applicable
- Personal Statement

Licensure Information

Indicate all states where you presently maintain active medical license(s):

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

☐ No ☐ Yes, Reason:

Have you ever been named in a malpractice case?

☐ No ☐ Yes, Reason:

How did you hear about this fellowship opportunity? *(please check all that apply)*

☐ Nemours Website
☐ Colleague
☐ Other:

Applicant's Certification

Are you able to carry out the responsibilities of a resident or fellow in the specialties and at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodation?*

☐ Yes ☐ No (*If No, please provide an explanation below. If additional space is needed, you may continue a separate page.)*

I certify that the information contained within my application and all attachments and supplemental information is complete and accurate to the best of my knowledge. I attest to the correctness and completeness of all information furnished. I understand that any false or missing information may disqualify me from consideration for a position; may result in an investigation by the AAMC per the AAMC Policies Regarding the Collection, Use and Dissemination of Resident, Intern, Fellow, and Residency, Internship, and Fellowship Application Data; may also result in expulsion from any match program; or if employed, may constitute cause for termination from the program. I authorize a representative of Nemours Children's Health to consult anyone who may have information bearing on my competence, ethics, character and other qualifications. I consent to the inspections, copying and release of all records and documents that may be material to evaluation of my competence, ethics, character and other qualifications. I fully release from any liability permitted by law, all individuals and organizations who provide information in good faith regarding my competence, ethics, character, and other qualifications, including confidential information.

_____ _____

Applicant's Signature Date

Send completed application and supporting documents to:

Jennifer Luther, Fellowship Manger
jennifer.luther@nemours.org
Nemours General Medical Education
6535 Nemours Parkway, Orlando FL 32827

For Office Use Only:

Complete Application Received by: _____ Date Received: _____

Dates of Fellowship: _____ to _____

Status: ☐ Accept ☐ Not Accept

Comments: _____

_____

Program Director Signature: _____ Date: _____