

COMMON APPLICATION FOR NATIONWIDE CHILDREN'S HOSPITAL  
GRADUATE MEDICAL EDUCATION

NCH Program: \_\_\_\_\_

Month/Year to begin program: \_\_\_\_\_



PROFILE

Last Name	First Name	Middle Initial	Suffix
Previous Last Name	Preferred Name	Gender	
Birth Place		Birth Date	
Social Security Number	Contact Email		

PRESENT MAILING ADDRESS/CONTACT INFORMATION

Country	Street Address		
City	State/Province	Zip Code	
Preferred Phone	Alternate Phone		
Pager	Mobile	Fax	

**EDUCATION (include only higher education)**

For each non-medical educational institution you have attended, please provide the requested information.

**Entry 1**

Institution		Education Type <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other	
City	State	Degree	
Dates of Attendance - From Month/Year To Month/Year			

**Entry 2**

Institution		Education Type <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other	
City	State	Degree	
Dates of Attendance - From Month/Year To Month/Year			

**Entry 3**

Institution		Education Type <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other	
City	State	Degree	
Dates of Attendance - From Month/Year To Month/Year			

**Entry 4**

Institution		Education Type <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Other	
City	State	Degree	
Dates of Attendance - From Month/Year To Month/Year			

**MEDICAL EDUCATION**

For each medical school you have attended, please provide the requested information.

**Entry 1**

Institution		Country
City	State	Degree
Dates of Attendance - From Month/Year To Month/Year		

**Entry 2**

Institution		Country
City	State	Degree
Dates of Attendance - From Month/Year To Month/Year		

**Entry 3**

Institution		Country
City	State	Degree
Dates of Attendance - From Month/Year To Month/Year		

**Entry 4**

Institution		Country
City	State	Degree
Dates of Attendance - From Month/Year To Month/Year		

Was your medical education training ever extended or interrupted?

Yes     No

Reason

--

### GRADUATE MEDICAL EDUCATION TRAINING

For each residency, fellowship or osteopathic training position you have held or currently are in, regardless of the amount of time spent there, please provide the requested information.

PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE
PROGRAM	PGY(s)	INSTITUTION	STATE/CITY	START DATE	END DATE

Was your training ever extended or interrupted?

Yes       No

Reason

### EXPERIENCE(S)

Provide the requested information for each relevant work, research, and volunteer experience/position. Include clinical and teaching experience as work experiences, and include all unpaid extracurricular activities and committees you have served on as volunteer experiences.

**Entry 1**

Organization	Experience Type
	<input type="checkbox"/> Work <input type="checkbox"/> Research <input type="checkbox"/> Volunteer
Position	Dates of Experience - From Month/Year To Month/Year
City	State/Province
	Country
Description:	

## Entry 2

Organization	Experience Type <input type="checkbox"/> Work <input type="checkbox"/> Research <input type="checkbox"/> Volunteer	
Position	Dates of Experience - From Month/Year To Month/Year	
City	State/Province	Country
Description:		

## Entry 3

Organization	Experience Type <input type="checkbox"/> Work <input type="checkbox"/> Research <input type="checkbox"/> Volunteer	
Position	Dates of Experience - From Month/Year To Month/Year	
City	State/Province	Country
Description:		

## Entry 4

Organization	Experience Type <input type="checkbox"/> Work <input type="checkbox"/> Research <input type="checkbox"/> Volunteer	
Position	Dates of Experience - From Month/Year To Month/Year	
City	State/Province	Country
Description:		

### EXAMINATIONS

For each examination you have taken, please provide the requested information. (Osteopathic applicants: include the exams (COMLEX or USMLE) that lead to the medical licensure route you intend to pursue.)

EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)	Month/Year	Status <input type="checkbox"/> Passed <input type="checkbox"/> Awaiting results <input type="checkbox"/> Failed <input type="checkbox"/> Will take <input type="checkbox"/> Incomplete	Score(s)
EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)	Month/Year	Status <input type="checkbox"/> Passed <input type="checkbox"/> Awaiting results <input type="checkbox"/> Failed <input type="checkbox"/> Will take <input type="checkbox"/> Incomplete	Score(s)
EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)	Month/Year	Status <input type="checkbox"/> Passed <input type="checkbox"/> Awaiting results <input type="checkbox"/> Failed <input type="checkbox"/> Will take <input type="checkbox"/> Incomplete	Score(s)
EXAM (ex USMLE Step 1, NBME Part 1, COMLEX Step 1, etc.)	Month/Year	Status <input type="checkbox"/> Passed <input type="checkbox"/> Awaiting results <input type="checkbox"/> Failed <input type="checkbox"/> Will take <input type="checkbox"/> Incomplete	Score(s)

### STATE MEDICAL LICENSE(S)

For each state license you have, please provide the requested information.

State	License Type <input type="checkbox"/> Full <input type="checkbox"/> Temporary or Limited <input type="checkbox"/> Inactive	License Number	Expiration Month/Year
State	License Type <input type="checkbox"/> Full <input type="checkbox"/> Temporary or Limited <input type="checkbox"/> Inactive	License Number	Expiration Month/Year
State	License Type <input type="checkbox"/> Full <input type="checkbox"/> Temporary or Limited <input type="checkbox"/> Inactive	License Number	Expiration Month/Year

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

Yes       No

Reason

Have you ever been named in a malpractice case?

Yes       No

Reason

Is there anything in your past history that would limit your ability to be licensed or receive hospital privileges?

Yes       No

Reason

Have you ever been convicted of a felony?

Yes       No

Reason

### PUBLICATIONS

List publications of the following types:

- Peer Reviewed Journal Articles/Abstracts
- Peer Reviewed Journal
- Articles/Abstracts -Submitted, Provisionally Accepted, Accepted or In-Press
- Peer Reviewed Book Chapter
- Scientific Monograph
- Other Articles
- Peer Reviewed Online Publication
- Non Peer Reviewed Online Publication

### PRESENTATIONS

List publications of the following types:

- Poster Presentation
- Oral Presentation

**AWARDS/ACCOMPLISHMENTS**

**MEMBERSHIPS IN HONORARY/PROFESSIONAL SOCIETIES**

**CITIZENSHIP AND VISA STATUS**

What is your citizenship status?

- |   |   |
|---|---|
| <input type="checkbox"/> U.S Citizen      | <input type="checkbox"/> Permanent Resident             |
| <input type="checkbox"/> Foreign National | <input type="checkbox"/> Conditional Permanent Resident |

Current Visa Type (for Foreign Nationals only)

- |   |   |
|---|---|
| <input type="checkbox"/> F-1 Academic student                 | <input type="checkbox"/> J-2 Spouse or child of J-1     |
| <input type="checkbox"/> H-1B Specialty occupation            | <input type="checkbox"/> EAD - Employment Authorization |
| <input type="checkbox"/> H-4 Spouse or child of H-1, H-2, H-3 | <input type="checkbox"/> Immigrant                      |
| <input type="checkbox"/> J-1 Visa for exchange visitor        | <input type="checkbox"/> Other                          |

Expected Visa Type (for Foreign Nationals only)

Are you willing/able to obtain a J-1 visa prior to anticipated start date of the program?

- Yes  
 No

If obtaining a J-1 continuation, do you have sufficient time remaining on J-1 to complete the program (maximum duration of J-1 is 7 years)

- Yes  
 No

Additional comments



## INTERNATIONAL MEDICAL GRADUATES

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

- Yes  
 No  
 Not applicable

Month/Year of certification: \_\_\_\_\_

*To be answered by International Medical Graduates (IMG's) only:* Is there anything in your past history that would limit your ability to be licensed or receive hospital privileges?

- Yes  
 No

Describe limitation

## MISCELLANEOUS

Are you Board Certified?

- Yes  
 No

Board Name

Are you a member of Alpha Omega Alpha?

- Yes  
 No  
 Not applicable (osteopathic applicant or no AOA chapter at my school)

Are you a member of Sigma Sigma Phi?

- Yes  
 No  
 Not applicable (allopathic applicant or no SSP chapter at my school)

Are you ACLS (Advanced Cardiac Life Support) certified in the USA?

- Yes  
 No

ACLS certification expiration date: \_\_\_\_\_

Are you PALS (Pediatric Advanced Life Support) certified in the USA?

Yes

No

PALS certification Expiration date: \_\_\_\_\_

Do you have a DEA number?

Yes

No

DEA Registration Number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Language fluency, other than English:

Hobbies and Interests:

**Race and Ethnicity (Optional)**

This section allows entries for race and/or ethnicity identification. You may select one or more and/or enter additional race or ethnicity identification. You are not required to identify your race and/or ethnicity. If you choose not to identify your race and ethnicity, please select "No Answer."

No Answer

American Indian or Alaskan Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

Spanish/Hispanic/Latino

White

Other(s) \_\_\_\_\_

## PERSONAL STATEMENT

Do not exceed 750 words

## CERTIFICATION

I certify that the information contained within my application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; or if employed, may constitute cause for termination from the program

- Yes
- No

Signature \_\_\_\_\_ Date \_\_\_\_\_