**Common Application for Clinical Fellowship** Program Start Dates are Institution Driven\*\*

**PROGRAM:** Pediatric & Adolescent Gynecology

All PAG fellowship programs will accept this common application. Please save a copy for your use.



**GENERAL INFORMATION** NRMP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Last* |  | *First* | *Middle (complete)* |  | *Maiden (if applicable)* |
| Present Address: |  |  | Telephone: ( | ) |  | Preferred |
|  |  |  |  |  |  |  |  |
|  |  |  | Telephone: ( | ) |  | Alternate |
|  |  |  |  |  |  |  |  |
| E-mail address: |  |  | Pager Number |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Citizenship Status: | US Citizen | US Permanent Resident | J-1 visa | H1-B Visa |
| Canadian Citizen | CDN Permanent Resident |  |  | Other Nationality: Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you eligible or authorized to work in the US? |  |  | Yes | No | Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you able to practice in Canada? | Yes |  | No |  |  |  |  |  |  |
| **Military Service** |  |  |  |  |  |  |  |  |  |  |  |
| Were you in the U. S. Armed Forces? Yes |  |  | No | Branch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dates of Duty: From |  |  |  | To |  |  |  |  | Rank/Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



**MEDICAL LICENSURE**

|  |  |  |
| --- | --- | --- |
| State(s)/Province(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type: |  | Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you been or are you currently the subject of disciplinary proceedings by any state licensure agency? | Yes | No |
| Have you been or are you currently the subject of disciplinary proceedings by any hospital? | Yes | No |
| *If you answered yes to either, please explain on an additional sheet and attach to this application.* |  |  |



**BOARD ELIGIBILITY AND/OR CERTIFICATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Are you US board certified? | Yes | No | ABOG Certification date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If you are not yet certified, are you board eligible? | Yes | No If yes, when eligible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



Royal College of Physicians and Surgeons of Canada(FRCSC) Certification date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**EDUCATION**

Undergraduate

College/University: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State/Province if applicable and Country:

Dates Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree:

Medical School:

City/State/Province if applicable and Country:

Dates Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Graduation Date:

E.C.F.M.G. (if foreign trained outside of US): Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issue Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note: You must provide a copy of your valid ECFMG certificate*

TOEFL IBT (if foreign trained outside of Canada): Passing score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Note: Copy Must be provided*



**CURRENT & PRIOR TRAINING**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Internship |  |  |  |  |  |
| Institution: |  |  | Dates: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |
| Address/City/State or Province/Country: |  |  |  |  | \_\_\_\_ |
| Area of Training/Specialty: |  |  |  |  | Completed Program? Yes | No |
| Residency |  |  |  |  |  |
| Institution: |  |  | Dates: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address/City/State or Province/Country: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Area of Training/Specialty: |  |  |  |  | Completed Program? Yes | No |
| Fellowship |  |  |  |  |  |
| Institution: |  |  | Dates: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address/City/State or Province/Country: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 03/2019 |  |  |  |  |  |  |  |



|  |  |
| --- | --- |
| **Common Application for Clinical Fellowship** |  |
| **PROGRAM:** Pediatric & Adolescent Gynecology | Page 2 of 2 |  |
| Area of Training/Specialty: |  | Completed Program? Yes | No |



**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXPERIENCE**

|  |  |  |
| --- | --- | --- |
| **Organization & Location** | **Position** | **Dates** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Other Special Training, Skills, or Research Experience:



**AWARDS/ACCOMPLISHMENTS (you may expand on this section in your CV)**

**PUBLICATIONS & PRESENTATIONS (you may expand on this section in your CV)**

The following documents are required to support your fellowship application:

[ ] A minimum of three letters of recommendation. *One letter must be from the Director of your Residency Training Program*.

[ ] Current *curriculum vitae*

[ ] Copy of medical school diploma (with English translation if applicable)

[ ] ECFMG certificate (if applicable)

[ ] TOEFL IBT certificate (if applicable)

[ ] Personal statement of career goals, with discussion of how you plan to use this training

[ ] Official copy of USMLE or LCCE transcript

By my signature below, I certify that the information in this application is accurate.

*Signature:* *Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**NOTE: Each PAG fellowship program has requirements in addition to this common application. To ensure that your application is complete, please contact the program to which you are applying for information about their specific institutional requirements. A list of PAG fellowship programs is available on the web at** [**https://www.naspag.org/page/PAGFellowship**](https://www.naspag.org/page/PAGFellowship)**.**

**\*\* All programs will start in July, but specific start date is institution based.**