

GOLISANO CHILDREN'S HOSPITAL AT STRONG
UNIVERSITY OF ROCHESTER
SCHOOL OF MEDICINE AND DENTISTRY
601 ELMWOOD AVENUE, BOX 777
ROCHESTER, NEW YORK 14642

PHOTO

A recent photograph is not a
requirement but is very
helpful.

APPLICATION FOR PEDIATRIC
HEMATOLOGY/ONCOLOGY
FELLOWSHIP

NAME (Print): _____
First Middle Last

SOCIAL SECURITY NO.: _____

PRESENT ADDRESS: _____ Phone: _____
Street

City State Zip Code

PERMANENT ADDRESS: _____ Phone: _____
Street

City State Zip Code

PAGER: _____ BEST DAYTIME NUMBER TO REACH YOU: _____

E-MAIL ADDRESS: _____

NEAREST RELATIVE: _____ Relation: _____
(parent or other close relative through whom you can always be contacted)

ADDRESS OF RELATIVE: _____ Phone: _____
Street

City State Zip Code

DATE OF BIRTH*: _____

PLACE OF BIRTH*: _____ CITIZENSHIP*: _____

IF NOT US CITIZEN, Type of Visa: _____ Immigration No.: _____
(Only J-1 Visa is acceptable)

FOREIGN MEDICAL GRADUATES: If you are a graduate of a medical school outside the United States or
Canada, have you been certified by ECFMG?

Yes, ECFMG Number: _____

No

**The New York State Human Rights law prohibit discrimination because of race, creed, color, national origin, age, sex, disability, or marital status.*

Have you any health problems which may interfere with your performance of this job? Yes No
If yes, please state disability and any accommodation necessary for you to function in this job capacity:

Do you have any commitment for military or National Health Corps service? Yes No

EDUCATION: (Please include degrees to be granted and any non-degree work.)

<i>Degree (A.B., B.S., etc.)</i>	<i>University or College</i>	<i>Month</i>	<i>Year</i>
<i>Degree (M.D., D.D.S., etc.)</i>	<i>University or College</i>	<i>Month</i>	<i>Year</i>
<i>Other Degrees</i>	<i>University or College</i>	<i>Month</i>	<i>Year</i>

HOSPITAL AND CLINICAL EXPERIENCE:

<i>Position</i>	<i>Hospital</i>	<i>City</i>	<i>Dates</i>
<i>Position</i>	<i>Hospital</i>	<i>City</i>	<i>Dates</i>

Are you enrolled in the National Resident Matching Program? Yes No
(Note: Our program requires participation)

Fellowship start date: _____
Month *Year*

I hereby certify that the information in this application is correct. I understand that upon appointment that I will be required to document my citizenship and complete a health assessment, which includes a physical examination and drug and alcohol testing.

Usual Signature (written): _____

Application submitted: _____

List of materials required to complete your application:

1. Completed and signed application.
2. Updated *curriculum vitae*.
3. Personal statement telling us about yourself, your interests in Pediatric Hematology/Oncology, long-term plans and specific fellowship goals.
4. Recent photograph.
5. Foreign graduates: Should include copy of ECFMG certificate. ECFMG certification is required of all foreign medical graduates.
6. Include a copy of your USMLE Step I Score Certificate.
7. Four letters of reference addressed to: Craig A. Mullen, M.D., Ph.D. Letters should be from the Chair of Pediatrics, Director of Pediatric Hematology/Oncology and two other faculty members who are affiliated with the candidates work.

Mail all application materials to:

Craig A. Mullen, M.D., Ph.D.
Professor of Pediatrics
Chief, Pediatric Hematology/Oncology
University of Rochester Medical Center
601 Elmwood Avenue, Box 777
Rochester, New York 14642

Applications will be processed only after the above have been received.