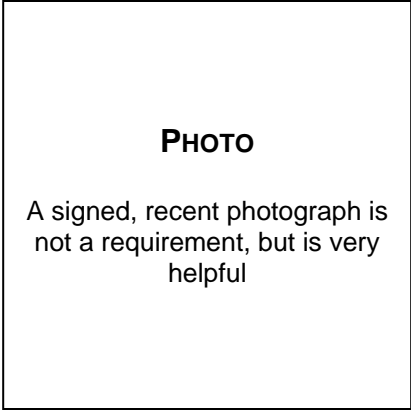


GOLISANO CHILDREN'S HOSPITAL AT STRONG
OF THE UNIVERSITY OF ROCHESTER
601 ELMWOOD AVENUE, BOX 651
ROCHESTER, NEW YORK 14642
585-275-5884
585-461-3614 (Fax)



APPLICATION FOR INTERNSHIPS, RESIDENCIES AND FELLOWSHIPS

Name (print): _____
First Middle Last

Social Security No: _____

Present Address: _____
Street

City State Zip

Permanent Address: _____
Street

City State Zip

E-Mail Address: _____ Pager #: _____

Home Phone #: _____ Work Phone #: _____ Fax #: _____

Cell Phone #: _____

Date of Birth (mm/dd/yyyy): _____ Place of Birth: _____

Citizenship: _____

If not a U.S. Citizen:

Type of Visa: _____

Immigration #: _____

Foreign Medical Graduates: ECFMG No: _____
Standard or Interim?

Have you passed the Visa Qualifying Examination?: _____

Name of Spouse or Nearest Relative: _____
Relation

Address of Spouse or Nearest Relative: _____
Street

City State Zip

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

Do you have any commitment for military of National Health Corps. Service? (Please explain)

Education: (Please indicate degrees to be granted on any non-degree work)

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

USLME Step 1 Score _____ USLME Step 2 Score _____ USLME Step 3 Score _____

Hospital and Clinical Experience, If Any:

Position	Hospital	City	Date(s)
Position	Hospital	City	Date(s)

Have you ever been disciplined by, dismissed from, or not reappointed to a previous residency or fellowship program?
Yes _____ No _____ If so, provide details on separated sheet.

Can you come for a personal interview? _____

A personal interview is not a requirement, but is strongly recommended. Time of the interview must be arranged in advance.

Are you enrolled in the National Intern and Resident Matching Program? _____

Position Desired: _____
(Intern, Assistant Resident, Associate Resident, Resident or Fellow)

Service: _____ **Service to Begin:** _____
Medicine, Surgery, Pediatrics, etc.

Signature (written): _____ **Date:** _____

For Neonatal-Perinatal Medicine Fellowship Program:

Mail the following items to: Ronnie Guillet, M.D., Ph.D., Director, Neonatal-Perinatal Medicine Fellowship Program, 601 Elmwood Avenue, Box 651, Rochester, New York, 14642.

1. Completed application
2. Curriculum Vitae
3. Personal Statement telling us about yourself, your interest in Neonatology, long-term plans, and specific fellowship training goals.
4. Ask at least four members of the residency program in which you trained, including the Chair of Pediatrics and the Chief of Neonatology, to send a letter of recommendation directly to Dr. Guillet.
5. Foreign graduates: Should include copy of ECFMG Certification

*****THIS APPLICATION BECOMES – FOR THOSE APPOINTED – A PERMANENT RECORD*****