Barrow Neurological Institute at Phoenix Children's Hospital
1919 E. Thomas Road
Phoenix, AZ 85016
Phone: 602-933-0447

Application for Pediatric Neurocritical Care Fellowship

I hereby apply for a position as the Pediatric Neurocritical Care Fellow at Barrow Neurological Institute at Phoenix Children's Hospital.
Academic Year Appling for _______________
(Academic Year Starts July 1 through June 30, fellowship duration 12 months)

Tracks: ***Neurology Track*** (for Pediatric Neurologists) ☐ ***Critical Care Track*** (for Pediatric Intensivists) ☐

Full Name:____M.D._______ M.B.B.S ______ D.O._______

Present Address:____

City:__________________________State:_____________Zip:__________Country:_______________

Telephone:_____________________________________

E-Mail Address:__________________________Fax No.:________________________________

Permanent Address:____

Place of Birth:_______________________Date of Birth:______________

U.S. Citizen ___ Yes ____ No If no, County of Citizenship: ____________ Permanent Resident ____Yes ____No

SSN# ___________________________________

ECFMG Certificate No._________________ Type if Visa________________

Education:

Medical School_____________________________________ Year Completed/ Graduated_________________

Undergraduate School_______________________________ Year Completed/ Graduated__________________

Do you hold a state Medical License? ______ Yes ______ No

State(s) in which you hold a Permanent license to practice Medicine

State _______________________ License #______________ Expiration Date _______________

State _______________________ License #______________ Expiration Date _______________

Have you ever been denied a medical License or had a license revoked ? _____ Yes ______ No

If yes, explain why:____

U.S. Licensing Exams passed (attach copy of scores for each exam):

USMLE Scores/ Percentile
_____ Yes _____ No Step I _____ % _____ Step II _____ % _____ Step III_____ % _____

Residency/Fellowships/Internship:

Other education, training or clinical research experience: (please list in chronological order, including your present position)

University/Hospital	Type of Training	Specialty	Dates	ACGME Accreditation

References:

Please list the names and institutions of three physicians who will be writing letters for you:

Name	**Title**	**University/Hospital**

Why do you want to pursue fellowship training in pediatric neurocritical care?
____
____
____

What sets you apart from other applicants?
____
____
____

SIGNATURE OF APPLICANT:_________________________________DATE:___________________

Please send this form and a copy of your CV to the fellowship program administrator, Tania Mays at tmays@phoenixchildrens.com or Fax: (602) 933-4253. One of the letters of recommendation must be from your program director. Click on box to enter your information. You can then Save and Print your completed form.