Application for Pediatric Neurocritical Care Fellowship

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

I hereby apply for a position as the Pediatric Neurocritical Care Fellow at Barrow Neurological Institute at Phoenix Children's Hospital.

Academic Year Applying 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 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, a copy of your CV and letters of recommendation 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.