

# BAYLOR COLLEGE OF MEDICINE PEDIATRIC FELLOWSHIP APPLICATION

**DEPARTMENT OF PEDIATRICS  
BAYLOR COLLEGE OF MEDICINE  
ONE BAYLOR PLAZA  
HOUSTON, TEXAS 77030**

provide a small  
passport style photograph  
in this space

Application for fellowship appointment in (specialty):	Level of training applied for:	Beginning (MO) (DAY) (YEAR)
--	--------------------------------	-----------------------------

Name Last	First	Middle	Present Address		
Telephone (Home)		Telephone (Hospital or School)		Social Security Number	
Permanent Home Address			Name and address of someone always able to contact you		
Birthdate (MO) (DAY) (YEAR)		Place of birth		Citizenship	
If non-citizen, date of entry into U.S.					
If non-citizen, type of Visa held (Exchange Visitor, Immigrant, etc.)					
Do you have any conditions which might impair your participation in the program? If so, please describe.					

**EDUCATION:**

High School		From	To	
	Address			
College		From	To	Degree
		From	To	Degree
Medical School		From	To	Degree
	Address			
Other Degrees		From	To	Degree
	Address			

If a graduate of a foreign medical school, have you obtained certification from the Educational Commission for Foreign Medical Graduates? \_\_\_\_\_  
 Indicate exams passed: ECFMG \_\_\_\_\_, Visa Qualifying Examination (VQE) \_\_\_\_\_, Foreign Medical Graduate Exam in the  
 Medical Sciences (FMGEMS) \_\_\_\_\_, National Board Exam (parts 1-2-3) \_\_\_\_\_, United States Medical Licensing Examination (USMLE)  
 steps 1-2-3) \_\_\_\_\_, or FLEX \_\_\_\_\_. Please enclose notarized copies of your exam results and ECFMG certificate.

Internship,	Hospital	From	To	Field
	City and State			
Residency	Hospital	From	To	Field
	City and State			
And	Hospital	From	To	Field
	City and State			
Fellowship	Hospital	From	To	Field
	City and State			
	City and State			
Graduate School	College(s)	From	To	Degree(s)
	Field(s)			

Membership in Honorary or Professional Societies, prizes, awards, fellowship, etc. Please include AOA membership.

---



---



---

PROFESSIONAL GOALS AND CAREER PLANS (Omit if included in CV or Personal statement.)

---



---



---



---



---

U. S. Board certification or eligibility	Specialty	Certified or Eligible (circle one)	Date of certification
	Specialty	Certified or Eligible (circle one)	Date of certification

**MEDICAL LICENSURE:** State \_\_\_\_\_ year issued \_\_\_\_\_

State \_\_\_\_\_ year issued \_\_\_\_\_

Faculty	College	From	To
	Department	Rank	
Appointments	College	From	To
	Department	Rank	

Practice or other clinical experiences	Location	From	To
	Type		
	Location	From	To
	Type		

**CURRICULUM VITAE: PLEASE ATTACH COPY AND, IF APPLICABLE, A LIST OF PUBLICATIONS.**

**REFERENCES:** Please list four references, of whom one must be your residency program director and three must be physicians who can render an evaluation of your professional and academic abilities. Please ask that your recommenders comment on academic and personal attributes such as judgment, industry, interpersonal relationships, capacity to assume responsibility and professional ethics. Please have these recommendations sent directly to the director of the fellowship program.

Residency Program Director	Address
Other Recommenders	Address

I certify that to the best of my knowledge the above information is accurate and correct.

Date \_\_\_\_\_ Signature \_\_\_\_\_