



**NEW YORK UNIVERSITY
SCHOOL OF MEDICINE**

Attach photo here

Application for Fellowship in General Academic Pediatrics

NAME _____
last first middle

HOME ADDRESS	TELEPHONE
	CELLPHONE
	PAGER
	EMAIL

PRESENT POSITION

TITLE
ADDRESS
TELEPHONE

EDUCATION (Include all undergraduate and graduate schools attended, in chronological order)

DATES ATTENDED	NAME OF INSTITUTION	ADDRESS	DEGREE / YEAR

RESIDENCY TRAINING PROGRAM(S) (Include all programs attended, in chronological order)

DATES ATTENDED	NAME OF INSTITUTION	ADDRESS	DEPARTMENT / POSITION

LICENSES / CERTIFICATIONS

MEDICAL LICENSE(S): For each, please list state and registration #		
USMLE SCORES		
Step 1:	Date:	Result:
Step 2:	Date:	Result:
Step 3:	Date:	Result:
OTHER LICENSING or CERTIFYING EXAMINATIONS: Please list examination, date and score		

OTHER INFORMATION

DATE OF BIRTH	PLACE OF BIRTH
SOC SEC NUMBER	CITIZENSHIP
LANGUAGES SPOKEN	

This application requires your current **Curriculum Vitae**, **three** letters of recommendation, one of which should be from the **director of your residency training program**, and a current **photograph** (passport size). In addition, please provide a transcript or report of your USMLE or any other licensing or certification examination scores.

Please attach to this application a succinct **personal statement** describing the development of your career plans and your specific interests and goals in ambulatory pediatrics. If you have additional accomplishments, experiences or qualifications that you wish considered, please include them.

Accepted candidates will be required to provide proof of completion of an accredited pediatric residency program, a current New York State Medical License or Limited Permit, and a certificate as to their past and present health in order to be appointed.

PLEASE MAIL COMPLETED APPLICATIONS TO:

Ms. Shelah McDaniel
 New York University School of Medicine
 Department of Pediatrics
 550 First Avenue
 New York, NY 10016

SIGNATURE	DATE
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