**Academic General Pediatrics Fellowship Programs Common Application**

**[JHU PROGRAM]**

**JHU Application Due Date: Sept. 30, 2024; Start Date: Jul. 1, 2025**

Fellowship Programs: (\*Indicates an Academic Pediatric Association accredited program).

Arkansas Children's Hospital

Baylor College of Medicine\*

Boston Children's Hospital\*

Children's Hospital Los Angeles\*

Children's Mercy Kansas City\*

Cohen Children's Medical Center\*

**Johns Hopkins School of Medicine\***

Nationwide Children's Hospital, Columbus Ohio

Nemours\*

Stanford School of Medicine\*

University of Rochester\*

University of Pittsburgh/UPMC Children's Hospital of Pittsburgh

Vanderbilt University Medical Center

**Johns Hopkins Application Checklist:**

Please email the following materials to Sara Johnson, Program Director: [sjohnson@jhu.edu](mailto:sjohnson@jhu.edu) by 11:59 pm EST on Sept. 30, 2024:

* This application form, completed and signed
* A 1-page personal statement
* A current curriculum vitae (CV)
* In addition, please request 3 letters of recommendation (if you are within 5 years of residency, one should be from your residency program director or their designee). Letters should be accompanied by a [confidential reference report](chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https:/www.academicpeds.org/wp-content/uploads/2019/11/Reference_Report.pdf). Letters should be emailed directly to Sara Johnson, Program Director: [sjohnson@jhu.edu](mailto:sjohnson@jhu.edu) by the referees.

Questions? Please reach out to Dr. Sara Johnson, Program Director ([sjohnson@jhu.edu](mailto:sjohnson@jhu.edu)) or Lynette Forrest, Medical Training Program Administrator ([lforres2@jhmi.edu](mailto:lforres2@jhmi.edu))

**I. PERSONAL INFORMATION**

1. **Profile:**

Last Name: First Name: Middle Initial: Suffix:

Previous Names:

Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  
Email:

Phone:

Emergency Contact Name:

Emergency Contact Phone:

Mailing Address

Street Address

City State Zip/Postal Code

Citizenship (Choose one):

☐ US Citizen

☐ US Permanent Resident

☐ Other (please specify):

1. **Visa Status & ECFMG/TOEFL Scores**

*If you are a foreign national outside the US, or currently in the US on a valid visa status, please respond to the questions in Section I.B. Note that our ability to consider individuals who are foreign nationals varies based on restrictions placed on funding. If this does not apply to you, please skip to Section II.*

Will you need a “visa sponsorship” through the teaching hospital (J1, H1B, etc.) to participate in US fellowship training?

☐ Yes à Please specify type of Visa: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ No

Did you train at a foreign medical school? ☐ Yes ☐ No

Is your medical school listed on the approved list for state licenses to which you will be applying?

☐ Yes ☐ No ☐ Unsure

🡪 If you are **unsure**, please contact the programs to which you are applying. Obtaining a license for the state in which you will be training is mandatory to begin fellowship.

ECFMG/TOEFL Scores

Please provide documentation for your ECFMG and/or TOEFL scores in the space below.

**II. EDUCATION AND TRAINING**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name of Institution | From (MM/YYYY) | To (MM/YYYY) |
| **College/University** |  |  |  |
| City, State |  | Degree: | |
| **Medical School** |  |  |  |
| City, State |  | Degree: | |
| **Internship** |  |  |  |
| City, State |  | Degree (if any): | |
| **Residency** |  |  |  |
| City, State |  | Degree (if any): | |
| **Other Training** |  |  |  |
| City, State |  | Degree (if any): | |

Was your medical education/training extended or interrupted? ☐ Yes ☐ No

🡪If **YES**, please note the date and comment:

**III. LICENSURE INFORMATION**

*This section allows entries for each of your state medical licenses. If you do not have a medical license, skip to Section IV.*

Have you passed USMLE Step 3? ☐ Yes ☐ No

Current Medical License(s)

**License 1**

* State:
* License Type:
* License #
* Expiration (MM/YYY):

**License 2**

* State:
* License Type:
* License #
* Expiration (MM/YYY):

**DEA Registration (US Medical License holders only)**

DEA Registration Number:

Expiration (MM/YYYY):

Has your medical license ever been suspended, revoked, or voluntarily terminated? ☐Yes ☐ No

🡪If **YES**, please note the date and comment:

Have you ever been named in a malpractice case? ☐ Yes ☐ No

🡪If **YES**, please note the date and comment:

Is there anything in your past history that would limit your ability to be licensed or would limit your ability to receive hospital privileges? ☐ Yes ☐ No

🡪If **YES**, please note the date and comment:

**IV.** **BOARD CERTIFICATION**

Are you Board Certified? ☐ Yes ☐ No

🡪If **YES**, Board Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🡪If **NO**, will you be Board Eligible by the beginning of the fellowship? ☐ Yes ☐ No

Are you Board Certified/eligible for more than one Board? ☐ Yes ☐ No

🡪If **YES**, will you be eligible for a second Board by the beginning of the fellowship? ☐ Yes ☐ No

Second Board Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V. MISCELLANEOUS**

Are you able to carry out the responsibilities of a fellow in Academic General Pediatrics and at the specific training program to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations? ☐ Yes ☐ No

🡪If **NO** If NO, please explain:

**VI. LETTERS OF RECOMMENDATION**

Please provide three (3) letters of recommendation. If you are within five years of residency training, one letter must be from your Residency Program Director or their designee. Make sure each letter writer receives a Confidential Reference Report. A report must be submitted alongside each letter of recommendation. Letter writers should submit their letters of recommendation along with a Confidential Reference Report via email directly to each Fellowship Program Director. Please see **Appendix 1** for a comprehensive list of email addresses.

|  |  |  |  |
| --- | --- | --- | --- |
| Reference 1 |  |  |  |
| Name |  | Address |  |
| Title |  | Email |  |
| Institution |  | Phone |  |
|  |  |  |  |
| Reference 2 |  |  |  |
| Name |  | Address |  |
| Title |  | Email |  |
| Institution |  | Phone |  |
|  |  |  |  |
| Reference 3 |  |  |  |
| Name |  | Address |  |
| Title |  | Email |  |
| Institution |  | Phone |  |

**VII. PERSONAL STATEMENT**

Please attach a one-page personal statement explaining why you want to complete a fellowship in Academic General Pediatrics. Please include the following: a description of your career goals, how the fellowship may assist you in achieving them, your scholarly/research interests, and how you envision your career five years after completion of this fellowship. You may want to include how past experiences have influenced your decision to apply and mention special areas of interest. (Please include your name on the attachment.)

**VIII. CURRICULUM VITAE**

Please attached a current curriculum vitae.

**IV. ATTESTATION**

I certify that the information contained in this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position, or if employed, may constitute cause for termination from the program. I also understand and agree that the data included in this application may be shared within the fellowship programs to which I am applying.

**I agree with the above attestation**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature** **Date (MM/DD/YYYY)**