Boston Children's Hospital
Until every child is well™

Department of Pathology, Farley 190, 300 Longwood Avenue, Boston, Massachusetts 02115, (617) 355-7431

PRELIMINARY APPLICATION FOR HOUSE STAFF

Service_____	Date Available for Appointment_____
Title of Appointment_____	PG Level (if applicable)_____
Name_____ First Middle Last	Social Security Number_____
Present Address_____	
Telephone Number_____	
Permanent Address_____	

LICENSURE Massachusetts _____ Permanent _____ Limited _____ None	Number _____ Sponsoring Hospital _____
Other (state where) _____	

IF YOU ARE NOT A CITIZEN OF THE UNITED STATES

What type of VISA will you hold while at Boston Children's Hospital?

_____

If you are living outside of the United States and contemplate entry as an exchange visitor, complete below.

___Male ___Female ___Single ___Married ___Widowed ___Divorced ____Separated

Date of Birth_____ Month Day Year	Country of Birth_____
Place of Birth_____ City and State or Providence	Country of Citizenship_____

Full name of wife or husband_____

Have you previously been in the United States as an exchange visitor? ___Yes ___No

If EV is to be accompanied by dependents, list on a separate sheet names, relationships, dates and places of birth, and nationalities for each family member.

A graduate of a foreign medical school (except Canada) who will have any clinical responsibilities is required to be certified by the Educational Council for Foreign Medical Graduates (ECFMG).

If you are certified, indicate below:
Standard Certificate: Number_____(photocopy must be enclosed)
Interim Certificate: Number_____(photocopy must be enclosed)
Date of Passing ECFMG Exam_____
Have you taken and passed the Visa Qualifying Examination (VQE)? ___Yes ___No

COLLEGE AND MEDICAL SCHOOL EDUCATION

Institution	Degree	Date

HOSPITAL AND CLINICAL EXPERIENCE
(If internship, be specific as to type, i.e., rotation, medical, pediatric, surgical, etc.)

Institution	Position (PG Level if applicable)	From	To

If you are the recipient of a fellowship, stipend, or other professional grant, give name of donor.

Donor Name_____	Duration: From_____ To_____
Amount of support provided_____	Has the amount actually been awarded? ___Yes ___No

MEMBERSHIP IN SOCIETIES

_____

_____

REFERENCES
(Full address, telephone, and fax number with each. Please have three references write directly to the Director of the Training Program.)

_____

_____

_____

Please arrange for your medical school to send your transcript and medical student performance evaluation. These should be sent directly to our Program Coordinator.
Please attach to this application a personal statement and a copy of your CV.

SIGNATURE OF APPLICANT_____Date_____