City of Hope

Graduate Medical Education
Non- ACGME Fellowship Application

Applicant Name		
Last name	*First*	*Middle*

Fellowship Type
This application is being made for a fellowship in (please check one):
☐ Advanced Hematopathology
☐ Community Practice Surgical Oncology
☐ Hematopoietic Cell Transplantation & Cellular Therapy
☐ Lymphoma
☐ Neurosurgical Oncology
☐ Reconstructive Urology and Genitourinary Cancer Survivorship
☐ Urologic Oncology and Robotic Surgery
☐ Other, please specify:

Please affix a recent passport-sized photo here.

If submitting electronically, include a recent passport-style photo in .JPG format with the application.

Training period for which applying:	*Start date*	*Finish date*

Current PGY (Approved Training Level):

Personal Data

Other names used:

California Medical License Requirements

You have graduated from a US. or Canadian medical school or international medical school approved by the Board pursuant to Business and Professions Code section 2084 and completed **36 months of accredited postgraduate training** with at least 24 consecutive months completed by the same program, passed all required examinations, and now you're eligible for the physicians and surgeon (P&S) License. Click here to learn more.

☐ **By checking here, I am acknowledging that I meet the requirements for the California Physician andSurgeon licensure.**

Present Address

Street	*City*	*State*	*ZIP / Postal code*

Permanent Address

Street	*City*	*State*	*ZIP / Postal code*

Telephone

Home	*Work*	*Mobile*	*Fax*

E-mail:

Citizenship

Country of citizenship	*Visa status*

Education

(Mo/Yr) to *(Mo/Yr)*	*(Undergraduate School)*	*(Major)*	*(Degree)*
(Mo/Yr) to *(Mo/Yr)*	*(Graduate School, if applicable)*	*(Major)*	*(Degree)*
(Mo/Yr) to *(Mo/Yr)*	*(Medical School)*	*(Country)*	*(Degree)*
(Mo/Yr) to *(Mo/Yr)*	*(Residency)*		*(Specialty)*
(Mo/Yr) to *(Mo/Yr)*	*(Other GME, if applicable)*		*Area of training*
(Mo/Yr) to *(Mo/Yr)*	*(Other GME, if applicable)*		*Area of training*

Other Experience

In chronological order, list other educational experiences, jobs, military service or training that is not accounted for above.

(Mo/Yr) to *(Mo/Yr)*	
(Mo/Yr) to *(Mo/Yr)*	
(Mo/Yr) to *(Mo/Yr)*	

National Boards

Please indicate national board examination dates and results received.

USMLE Step 1		**USMLE Step 2**				**USMLE Step 3**	
Date passed	*Score (optional)*	***CK*** *- Date passed*	*Score (optional)*	***CS*** *- Date passed*	*Score (optional)*	*Date passed*	*Score (optional)*

For graduates of international medical schools, are you ECFMG-certified? ☐ Yes ☐ No *If yes, provide certificate number and date granted.*

ECFMG Certificate Number	*Date ECFMG Certificate Granted*
	MM-YYYY

COMLEX Level 1		**COMLEX Level 2**		**COMLEX Level 3**	
Date passed	*Score (optional)*	*Date passed*	*Score (optional)*	*Date passed*	*Score (optional)*

Medical Licensure

Please list any states in which you hold a license to practice medicine. Please provide a license number. If an application is pending in a state, please write "pending."

(State)	*(Date Issued)*	*(Medical License Number)*	*(Active?)* ☐ Yes ☐ No
(State #2)	*(Date Issued)*	*(Medical License Number)*	*(Active?)* ☐ Yes ☐ No

Have you ever been reprimanded, or had your license suspended or revoked in any of these states?	☐ Yes *(If so, please explain in an attached sheet.)* ☐ No
Have you ever been named in (and/or had a judgment against you) in a medical malpractice legal suit?	☐ Yes *(If so, please explain in an attached sheet.)* ☐ No

Last Name, First Name:

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Board Certification

Please indicate any areas of board certification.

Board	*Area of Certification*	*Date of Certification*

Honors, Awards, Publications, Presentations, Memberships, Leadership/Research Experience

Please list on attached application forms or include this information in your CV.

Letters of Recommendation and/or References

Please list the individuals who will write your letters of recommendation. At least three are required.

Reference #1

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Reference #2

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Reference #3

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Reference #4 (optional)

Name	*Title*		
Institution			
Address	*City*	*State*	*ZIP / Postal Code*
Telephone	*Email*		

Honors and Awards ***(if explicitly listed on CV, include highlights here with reference to location on CV)***

Publications and Presentations ***(if explicitly listed on CV, include highlights here with reference to location on CV)***

Last Name, First Name:

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ATTESTATION QUESTIONS Please answer the following questions "Yes" or "no". If you answer **"yes"** to any questions please provide full details on separate sheet.		
1.	Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending?	**Select**
2.	Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending?	**Select**
3.	Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	**Select**
4.	Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	**Select**
5.	Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	**Select**
6.	Have you ever been denied certification/recertification by a specialty board?	**Select**
7.	Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation?	**Select**
8.	a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? b. Are any such actions pending?	**Select**
9.	Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please provide professional liability action explanation on a separate sheet.	**Select**
10.	Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please provide professional liability action explanation on a separate sheet.	**Select**
11.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	**Select**
12.	Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.	**Select**
13.	Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs?	**Select**
14.	Within the last two (2) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs?	**Select**

Memberships and Leadership/Research Experience ***(if explicitly listed on CV, include highlights here with reference to location on CV)***

Last Name, First Name:

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STATEMENT OF APPLICANT

I hereby:

* acknowledge that it is my duty and ethical responsibility as an applicant for rotation, to cooperate with and assist City of Hope Graduate Medical Education and medical staff in evaluating my qualifications, competence, and accordingly signify my willingness to appear for interviews in regards to my application;

* authorize the Hospital, Graduate Medical Education, and its Medical Staff, to consult with and obtain information from applicable state and federal licensing, certification and data collection agencies, previous and current insurance carriers, administrators and members of medical staffs of other hospitals, orinstitutions with which I am or have been associated, my present and prior associates, or others who may have information bearing on my qualifications, competence and character;

* consent to the release, to the Hospital, Graduate Medical Education, and its Medical Staff, of all information, including documents, which may be material to an evaluation of my qualifications, competence and character;

* release from liability, the Hospital, Graduate Medical Education, and its Medical Staff, for acts performed and statements made in good faith and without malice in connection with evaluating my application andmy qualifications, competence and character;

* release from liability, any and all individuals and organizations who provide information to the Hospital Graduate Medical Education, or the Medical Staff in good faith and without malice concerning my qualifications, competence and character;

* acknowledge that I have received, or been given access to, the Graduate Medical Education (GME) Handbook and GME Policies and Procedures, applicable Medical Staff Bylaws and Rules & Regulations, including but not limited to Rule & Regulation Section 30.9, “Utilization of Fellows, Residents and Medical Students” as referenced on the GME website (**www.cityofhope.org/gme**) and agree to be bound by the terms thereof;

* agree to comply with State and Federal laws governing the practice of medicine, standards established by the Joint Commission on Accreditation of Healthcare Organizations, and the principles of medical ethics of the American Medical Association;

* acknowledge that I, as a Resident/Fellow or clinical Trainee making application for rotation, have the burden of producing adequate information for a proper evaluation of my qualifications, competence and character, and for resolving any doubts about such matters;

* agree that, during the time this application is being processed, I will update this application should there beany change in information initially provided;

* certify that I have no physical, mental, or emotional condition(s) that would preclude me from fulfilling my responsibilities as a clinical Trainee and exercising any clinical privileges, and that my physical and mental health are adequate for the satisfactory performance of my professional duties and activities, and agreethat I will submit to mental or physical examination(s), including testing for the presence of alcohol or controlled substances as requested from time to time by the Medical Staff or Graduate Medical Education;

* affirm that the information I have furnished in the application is true to the best of my knowledge and is furnished in good faith and acknowledge that any significant misstatements for omissions shall constitute cause for denial of appointment, or cause for modification or revocation.

Last Name, First Name:

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PLEASE NOTE:

Failure to complete this application form in a timely manner, withholding of requested information, or providing false or misleading information shall, by itself, constitute a basis for the denial of participation in the requested training program.

ATTESTATION (to be signed by all applicants)

By signing below, I, attest that all information contained on this application is true to the best of my knowledge.

Applicant Printed Name	Signature	Date

The Hospital will treat this information secured in connection therewith in strict confidence and will employ all reasonable safeguards to protect the applicant's privacy.

Last Name, First Name:

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Residents Forum Suggested Timeline for Application	
Beginning one-and-a-half years before the proposed start of a fellowship for which the application is being made, the following timeline is recommended:	
December 1	Deadline for receipt of the completed Residents Forum Standardized Application and all supporting documentation (letters of recommendation, etc.)
March 1	Deadline for program to make offers to applicants

Application Packet Check-list
✓ **Completed Standardized Fellowship Application Form with Signature**
✓ **Updated Curriculum Vitae (CV)**
✓ **Included cover letter and/or personal statement**
✓ **Checked with the fellowship director or coordinator whether there are other items that should be included**
✓ **Included photo**

Last Name, First Name:

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