# Nicklaus Children's Hospital

## Resident/Fellow Application Form

3100 SW 62ND Avenue, Miami, Florida 33155-3009
Medical Education: (305) 666-6511 x5873
www.nicklaushealth.org

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Badge Access☐ Meal Card☐
Series#☐ I.T.☐ Image#______
Initial______ Badge#__________

**Today's Date: ______ /_____ / ________**  **Date of Birth: ______ /_____ / ________**

**Name:** ____________________________________________
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

**Check One**
☐MD ☐DO
☐DMD ☐DDS

**Check One**
☐ Rot. Resident
☐ Rot. Fellow

**SOCIAL SECURITY# ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___**

**Scheduled rotation at Nicklaus Children's Hospital**

**Rotation Start Date:** _____ / _____ / _____
(MM) (DD) (YY)

**Rotation End Date:** _____ / _____ /_____
(MM) (DD) (YY)

**Department at NCH:** ______________________________

**Year in current program (PRG):** _______  **Total # of years in ACGME training (PGY):**________

**Primary Hospital of Training:** ____________________________________________
**Contact person at your institution:** ____________________________________________

**Current training *program* at primary hospital:** ____________________________________

**Initial training *program*:** ____________________________________________

*If Current training differs from Initial training please select reason:*
☐ Changed Program ☐ Completed Program
☐ Other ______________________________________

(Is this Base Year a simultaneous match?)
**Clinical Base Year training program**____________________ **Yes**☐ **No**☐

**Please check one - Is this rotation: Required** ☐ **Elective** ☐

**Are there any regulations by your program during this rotation? (i.e., clinic calls)**
____________________________________________________________________

**Do you have any current PALS certification?** ☐ Yes ☐ No _____________

**Please specify the days of the week and times you will be physically here at MCH:**
**Mon**________ **Tues**________ **Wed**_________ **Thurs**_______ **Fri**________
**Sat** ________ **Sun** ________

**Please submit a copy of your Florida Medical License.**
**Number:** _____________________________

**International Graduates Only:**
**Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?**
**Certificate Number:** _____________________ **Date Issued:** ______________

**Previous training and/or current employment since medical school graduation date:**

| Employer/Training Facility Name | City/State/Country | Employment Dates | | Residency Training Program |
|---|---|---|---|---|
| | | *From* | *To* | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Education

**Medical/Dental School:** ___________________________________

**Country:** _____________________________ **State:** ___________

**Date Graduated:** ______ /_____ / _______
(Month) (Day) (Year)

## Contact Information

**Address:** ________________________________________________

**City:** ______________________ **State:** _______ **Zip:** __________

**Email:** _______________________________

**Home #:** (_____) _________________

**Cell #:** (_____) _________________

**Pager #:** (_____) _________________ **Ext.**_______

**Emergency Contact:** ________________________________

**Relationship:** ________________ **Telephone:** (____) _______________

**I certify that the information contained within this application form is correct to the best of my knowledge.**

**Resident/Fellow Signature:** _____________________________________________