Academic General Pediatrics Fellowship Programs
Common Application [JHU PROGRAM]
JHU Application Due Date: January 15, 2024

Fellows' Start Date: July 1, 2024

1. Arkansas Children's Hospital
2. Baylor College of Medicine*
3. Boston Children's Hospital*
4. Children's Hospital Los Angeles*
5. Children's Mercy Kansas City*
6. Cohen Children's Medical Center*
7. Johns Hopkins*
8. Nationwide Children's Hospital, Columbus Ohio
9. Nemours*
10. Stanford School of Medicine*
11. University of Rochester*
12. University of Pittsburgh/UPMC Children's Hospital of Pittsburgh
13. Vanderbilt University Medical Center

**Indicates an Academic Pediatric Association accredited fellowship training program.*

Personal Information

Profile

First Name:	
Middle Name:	
Last Name:	
Suffix:	
Previous Last Name:	
Date of Birth:	
Email:	

Phone:	
Emergency Contact (Name and Number):	

Mailing Address

Street Address:	
City:	
State/Province:	
Zip/Postal Code:	

Citizenship

☐ US Citizen

☐ US Permanent Resident

☐ Other (Please list):

If you are a foreign national outside the US, or currently in the US on a valid visa status, please **note the programs that accept Visa applicants and respond to the questions below**. IF NOT A FOREIGN NATIONAL, SKIP TO THE SECTION LABELED "Education" below the ECFMG/TOEFL scores.

Programs that accept Visa applicants:

- University of Arkansas for Medical Sciences/Arkansas Children's Hospital
- Cohen Children's Medical Center
- Children's Mercy Kansas City
- Nemours Children's Hospital
- Stanford University

Will you need a "visa sponsorship" through the teaching hospital (J1, H1B, etc.) to participate in US fellowship training? ☐ Yes ☐ No

If YES to the question above:

- Please specify type of Visa:
- 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 state 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.

Education and Training

College/University:		From:		To:	
City, State:		Degree:			
Medical School:		From:		To:	
City, State:		Degree:			
Internship:		From:		To:	
City, State:		Degree:			
Residency:		From:		To:	
City, State:		Degree:			
Other Training:		From:		To:	
City, State:		Degree:			

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

If YES, please note the date and comment:

Licensure Information

This section allows entries for each of your state medical licenses.

Have you passed the USMLE Step 3? ☐ Yes ☐ No

Current Medical License(s)

(Note: If you do not have a current medical license, skip to the "Board Certification" questions.)

Entry 1:			
State:		License Number:	
License Type:		Expiration Month/Year:	
Entry 2:			
State:		License Number:	
License Type:		Expiration Month/Year:	
DEA Number *(DEA is for US Medical License holders only.)*			
DEA Registration Number		Expiration Month/Year:	

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

   If YES, please note the date and comment:

2. Have you ever been named in a malpractice case? ☐ Yes ☐ No
   If YES, please note the date and comment:

3. 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:

Board Certification

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

Board Name:

Are you Board Certified/eligible for more than one Board? ☐ Yes ☐ No
If YES, will you be Board Eligible by the beginning of the fellowship? ☐ Yes ☐ No

Board Name:

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, please explain:

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 his/her/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 and Title	
Contact Information	Address: Email: Phone:

Reference 2

Name and Title	
Contact Information	Address: Email: Phone:

Reference 3

Name and Title	
Contact Information	Address: Email: Phone:

Personal Statement

Please attach a one-page personal statement explaining why you want to complete a fellowship in Academic General Pediatrics and/or Primary Care. 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.)*

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:

Supplemental Biographical Information

The information requested is for statistical purposes only and will not be used during consideration of the application.

Date of Birth:	
Place of Birth:	
Gender:	

Ethnicity and Race (Self-identification):

Ethnicity:

☐ Of Hispanic or Latino origin (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race).

☐ Not of Hispanic or Latino origin

Race:

☐ Black or African American: A person having origins in any of the original groups of Africa.

☐ Asian or Asian-American: Includes persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent (e.g., Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).

☐ American Indian or Alaskan native: Includes persons having origins in any of the original peoples of North America and South American (including Central America), who mains tribal affiliation or community attachment.

☐ Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

☐ White: Includes persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

~~Disadvantaged Background:~~

An individual from a disadvantaged background is defined as someone who: Comes from an environment that has inhibited the individual from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school, or from a program providing education or training in an allied health profession. OR Comes from a family with an annual income below a level based on low-income thresholds according to family size published by the US Bureau of the Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary of Health and Human Services for use in health professions and nursing programs.

☐ Yes ☐ No

Checklist for Submission

[ ] Contact JHU Program Director Dr. Sara Johnson to indicate your interest and get additional information

[ ] Submit the following items via email directly to Dr. Johnson**:

- ✓ Completed APA Common Application (this document)
- ✓ Personal Statement – Please include your name on the attachment.
- ✓ Updated Curriculum Vitae

[ ] Instruct your three (3) letter writers to submit their letters of recommendation and a completed Confidential Reference Report (available here) via email directly to Dr. Johnson, below**.

Program Contacts for Questions and Submission:

Dr. Sara Johnson, Program Director, sjohnson@jhu.edu
Lynette Forrest, Program Coordinator, lforres2@jhmi.edu