## University Hospitals Case Medical Center Post Pediatric Portal Training Program Applicant Checklist

- □ Completed, signed, dated application
- Personal statement
- Current CV
- Letter of recommendation from your present training director if residency training was completed within the preceding 3 years
- 2 additional letters of recommendation specific to the Post Pediatric Portal Program from two attending physicians with whom you have worked (please include 1 additional letter if one is not completed by your training director)
- Copy of Medical School Diploma
- Medical School Transcripts (English translation for IMG's)
- Medical School Dean's Letter
- USMLE or COMLEX Official Transcripts
- Residency certificate of completion (if available)

## For Foreign Applicants

- Current Visa Status
- ECFMG Certificate

## Return all documents to Marquita.Dickerson@UHhospitals.org

Marquita N. Dickerson Associate GME Program Administrator Department of Psychiatry W.O. Walker Building – 8<sup>th</sup> Floor 10524 Euclid Avenue Cleveland, OH 44106-5080

Phone: 216-423-6185 Fax: 216-844-4741

Department of Psychiatry W.O. Walker Building 10524 Euclid Avenue Cleveland, OH 44106-5080

## **University Hospitals Cleveland Medical Center**

Application for Post Pediatric Portal Training Program
Academic Year Beginning July 1, 2027

Applications should be typed or printed. Please include all items listed in the Application Checklist (final page of application) with your completed application. Following receipt of your completed application and checklist materials, you will be notified if a personal interview is requested.

Name:			Date of Birth:							
Address (Home):				Email:						
Phone (Day):				Phone (Evening):						
Social Security#:			Citizenship:							
Education and Post Graduate Training:										
	School or Program		Location		Start	Date	Graduation Date		Degree or Specialty	
Undergraduate										
Medical School										
Internship										
Residency										
Other (if applicable)										
Post Residency Employment (if applicable):										
Position Location		Location		Start	Start Date		End Date		Reason for leaving	

If additional space is needed, please document on a separate sheet of paper and attach to application.

Foreign Medical School Graduates only:								
Type of Visa: (University Hospitals require a J-1 Visa).								
Do you intend to app	o you intend to apply for US citizenship?			YES	s	□no		
ECFMG Certificate	No:							
Attach copy of certifi	icate or	interim certif	icate a	ind copy	of scores.	If you are now in	the US,	give date and
Port of Entry:								
State or Professiona	al Licens	sure:						
State/Province	Licens	nse Type Lice		nse #		License Status (indicate active or inactive)		Issue Date
Board Certification:								
Name of Board			Certificate #				Issue Date	
Examination History	<u>:</u>							
Examination USMLE Step 1	,		(mm/y	y) Pass or Fail		-ail	Number of Attempts	
USMLE Step 2 CK								
USMLE Step 2 CS								
USMLE Step 3 COMLEX Level 1							-	
COMLEX Level 2 CI	E							
COMLEX Level 2 PE								
COMLEX Level 3								
Other:								
		any interruptio parate sheet			ning or em	ployment, please	describe	e the nature of the
Do you require any special accommodations to perform the essential functions of a resident physician								
in the trainin	in the training program at University Hospitals of Cleveland?							
If yes, please attach a separate sheet of paper explaining the required accommodation and how it would allow you to perform the essential functions of the position.								

1
Signature:
Date:

PHOTO – A recent photograph (in color, passport size is not a requirement, but is very helpful.)