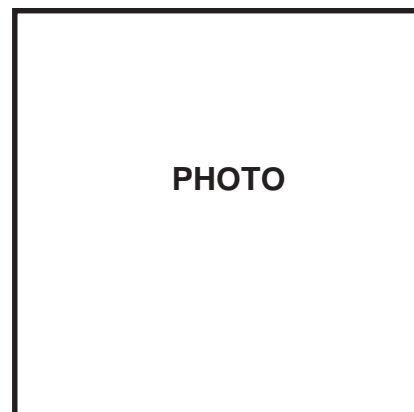


**APPLICATION FOR SUBSPECIALTY TRAINING**  
PEDIATRIC CRITICAL CARE MEDICINE  
UNIVERSITY OF FLORIDA, COLLEGE OF MEDICINE  
HEALTH SCIENCE CENTER PO BOX 100296  
GAINESVILLE, FL 32610



PHOTO

Today's Date \_\_\_\_\_

Date You Wish to Begin \_\_\_\_\_

**1. PERSONAL DATA**

Name In Full \_\_\_\_\_  
First Middle Last

Current Mailing Address \_\_\_\_\_  
Street

City State Zip Email address

Telephone Home \_\_\_\_\_ Office \_\_\_\_\_ Pager \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Nationality \_\_\_\_\_

**2. TYPE OF TRAINING DESIRED**

- A. \_\_\_\_\_ Three Years – Pediatric Residency required prerequisite.
- B. \_\_\_\_\_ Two Years – Prior subspecialty training and board eligibility in Pediatrics.
- C. \_\_\_\_\_ Two Years – Prior Pediatrics and Anesthesiology residencies.
- D. \_\_\_\_\_ Combined with a fellowship in \_\_\_\_\_.

**3. LICENSURE ELIGIBILITY REQUIREMENTS**

**A. Qualifying Examinations**

U S Medical Licensing Examination Dates Step 1 \_\_\_\_\_ Step 2 \_\_\_\_\_ Step 3 \_\_\_\_\_

ECFMG Number \_\_\_\_\_ Standard  Interim

FLEX: State \_\_\_\_\_ Date \_\_\_\_\_

**B. Licensure**

| State Of License | Expiration Date | Number |
|------------------|-----------------|--------|
|                  |                 |        |
|                  |                 |        |
|                  |                 |        |

Have you received medical licensure from a country other than the U.S.? \_\_\_\_\_

If so, Country \_\_\_\_\_ Province \_\_\_\_\_ Date \_\_\_\_\_

**4. EDUCATION AND EXPERIENCE**

Premedical College \_\_\_\_\_ Dates \_\_\_\_\_

Location \_\_\_\_\_ Degrees \_\_\_\_\_

Medical School \_\_\_\_\_ Graduation Date \_\_\_\_\_  
Month/Year

Location \_\_\_\_\_

Honors \_\_\_\_\_

Hospital currently working in \_\_\_\_\_

List chronologically your activities from the time of graduation from medical school *to the present*. Specify type of Internship or post MD specialty training.

| From/To | Activity | Place | Degree, If any | Program Director |
|---------|----------|-------|----------------|------------------|
|         |          |       |                |                  |
|         |          |       |                |                  |
|         |          |       |                |                  |
|         |          |       |                |                  |
|         |          |       |                |                  |
|         |          |       |                |                  |
|         |          |       |                |                  |
|         |          |       |                |                  |
|         |          |       |                |                  |

Membership in professional societies and others \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. MILITARY OBLIGATIONS**

In reserves? \_\_\_\_\_ If yes, what branch? \_\_\_\_\_

Dates Of Commitment \_\_\_\_\_

**6. LETTERS OF REFERENCE**

At least three letters of reference are required. One must be from the Dean of your medical school and at least two others should be from physicians who have observed or supervised you during medical school or during your PG1 or other recent training program, as applicable.

List below the names of all your references and have them write directly to us.

1. \_\_\_\_\_  
Name Address City State Zip

2. \_\_\_\_\_  
Name Address City State Zip

3. \_\_\_\_\_  
Name Address City State Zip

Others \_\_\_\_\_

**7. CITIZENSHIP (Check Appropriate Box)**

US Citizen  Non US Citizen

Immigrant Alien Alien Registration Number \_\_\_\_\_

Non Immigrant Alien Type Of Visa \_\_\_\_\_ Visa Number \_\_\_\_\_

**8. PLEASE WRITE A BRIEF DESCRIPTION (NOT MORE THAN ONE PAGE) OF YOUR GOALS AS A FUTURE PEDIATRIC CRITICAL CARE INTENSIVIST ON A SEPARATE SHEET.**

International Medical Graduates, who are not Native American English speakers, MUST complete the Test of the Spoken English Language. You must attain a score of a least 55 on this examination or your application for a fellowship cannot be considered. Evidence of achievement of this score or higher must be submitted or your application will not be considered. You can obtain information about this test from the following web site: <http://www.toefl.org>

ENCLOSE WITH THIS APPLICATION:

Recent photograph (passport type)  
If applicable:  
Copy ECFMG and USMLE Score Reports  
Copy Visa (for Non-Immigrant Alien)  
Copy Alien Registration Card  
(for Immigrant Non-Citizen)

MAIL APPLICATION, ENCLOSURES  
AND LETTERS OF REFERENCE TO:

Ann Marie LeVine, MD  
Associate Professor, Fellowship Program Director  
Pediatric Critical Care Medicine  
1600 SW Archer Road  
PO Box 100296  
Gainesville, FL 32610

\_\_\_\_\_  
**Signature of Applicant**