



Barrow Neurological Institute at Phoenix Children's Hospital  
 1919 E. Thomas Road  
 Phoenix, AZ 85016  
 Phone: 602-933-0447

### Application for Pediatric Movement Disorders Fellowship

I hereby apply for a position as the Pediatric Movement Disorders Fellow at Barrow Neurological Institute at Phoenix Children's Hospital.

Academic Year Applying for \_\_\_\_\_  
 (Academic Year Starts July 1 through June 30, fellowship duration 24 months)

Full Name: \_\_\_\_\_ M.D. \_\_\_\_\_ M.B.B.S \_\_\_\_\_ D.O. \_\_\_\_\_

Present Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

U.S. Citizen \_\_\_ Yes \_\_\_ No If no, County of Citizenship: \_\_\_\_\_ Permanent Resident \_\_\_ Yes \_\_\_ No

SSN# \_\_\_\_\_

ECFMG Certificate No. \_\_\_\_\_ Type if Visa \_\_\_\_\_

**Education:**

Medical School \_\_\_\_\_ Year Completed/ Graduated \_\_\_\_\_

Undergraduate School \_\_\_\_\_ Year Completed/ Graduated \_\_\_\_\_

Do you hold a state Medical License? \_\_\_ Yes \_\_\_ No

State(s) in which you hold a Permanent license to practice Medicine

State \_\_\_\_\_ License # \_\_\_\_\_ Expiration Date \_\_\_\_\_

State \_\_\_\_\_ License # \_\_\_\_\_ Expiration Date \_\_\_\_\_



Have you ever been denied a medical License or had a license revoked ? \_\_\_\_ Yes \_\_\_\_ No

If yes, explain why: \_\_\_\_\_

U.S. Licensing Exams passed (attach copy of scores for each exam):

USMLE Scores/ Percentile

\_\_\_\_ Yes \_\_\_\_ No Step I \_\_\_\_ % \_\_\_\_ Step II \_\_\_\_ % \_\_\_\_ Step III \_\_\_\_ % \_\_\_\_

**Residency/Fellowships/Internship:**

Other education, training or clinical research experience: (please list in chronological order, including your present position)

University/Hospital	Type of Training Specialty	Dates	ACGME Accreditation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**References:**

Please list the names and institutions of three physicians who will be writing letters for you:

Name	Title	University/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Why do you want to pursue fellowship training in pediatric movement disorders?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What sets you apart from other applicants?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_

Please send this form and a copy of your CV to the fellowship program administrator, Tania Mays at tmays@phoenixchildrens.com or Fax: (602) 933-4253. One of the letters of recommendation must be from your program director. Click on box to enter your information. You can then Save and Print your completed form.