



**UNIVERSITY OF SOUTH FLORIDA**

**GENERAL ACADEMIC PEDIATRIC FELLOWSHIP**

**APPLICATION**

**Instructions:**

Save the application form to your computer. Complete by putting your cursor in the grey areas and tab between them. Save the completed application, print, sign and mail it. You may also email all required documents and mail/fax the signature page.

- Completed and signed application
- A personal statement (up to 2 pages) describing your career goals, interests, and what you hope to achieve by completing the program
- A Curriculum Vitae – May be e-mailed
- Three letters of recommendation to be mailed directly

Mail the above documents to:

Sharon Dabrow, MD  
Professor of Pediatrics  
Director of the General Academic Pediatric Fellowship  
University of South Florida  
2 Tampa General Circle  
Tampa, FL 33606

PHONE: (813) 259-8752  
FAX: (813) 259-8749  
[sdabrow@health.usf.edu](mailto:sdabrow@health.usf.edu)

**THANK YOU FOR YOUR INTEREST IN THE  
USF GENERAL ACADEMIC PEDIATRIC FELLOWSHIP!**

**PERSONAL STATEMENT**

**Please submit a personal statement highlighting your career goals and interest and what you hope to achieve by completing the program**

# USF GENERAL ACADEMIC PEDIATRIC FELLOWSHIP APPLICATION

## Beginning Fellowship Year

**1. Name**

**Last**

**First**

**Middle**

**2. Date of Birth**

**(mm/dd/yyyy)**

**Place of Birth**

**3. Nationality: (Please Check One)**

**U.S. Citizen**

**Permanent Resident**

**Foreign National, Nationality**

**Visa Information**

**ECFMG Certificate #**

**Date**

**4. Present Address**

**(Home)**

**(#)**

**(Street)**

**(Apt)**

**(City)**

**(State)**

**(Zip)**

**Home Phone**

**Cell Phone**

**E-Mail**

**5. Work Address**

(City) (State) (Zip)  
 Phone  
 Fax

6. Do you hold a current medical license?  Yes  No (If No, go to 7.)

State License #

7. Board Eligible?  No  Yes, Specify Board

Board Certified?  No  Yes, Specify Board

8. Other Certifications?

- ACLS (Expiration Date )
- PALS (Expiration Date )
- NRP (Expiration Date )
- Other – Specify

9. Professional Memberships (Check all that apply)

- AAP
- APA
- SPR
- AMA
- Other – Specify

10. EDUCATION – Chronologically list below the educational institutions you attended post-college, dates, and degrees obtained.

Institution	Location/Address	Dates Attended	Degree & Date


**11. POST-GRADUATE CLINICAL TRAINING**

**Internship**

**(Institution)                      (Location/Address)                      (Dates)**

**Residency**

**(Institution)                      (Location/Address)                      (Dates)**

**(Institution)                      (Location/Address)                      (Dates)**

**Other Training (If any)**

**(Institution)                      (Location/Address)                      (Dates)**

**(Institution)                      (Location/Address)                      (Dates)**

**12. PROFESSIONAL EXPERIENCE**

**List any post-graduate work, practice experience, or other relevant work experience**

**Dates                      Type of Work (Describe)**

13. If time has elapsed since completing your residency training, please describe your activities (if not listed above)

14. Scholarly Activities:

List any scholarly activities (publications, posters, abstracts, etc...).

15. Honors and Awards:

List any honors and awards received.

16. Fellowship tracks you are interested in applying for:

Hospitalist

Outpatient (Choose an area of interest below if any)  
Interest/ Focus area(s)

Child abuse

Advocacy

Community & School Health

Adolescent Medicine

Child Health Policy and Outcomes

17. Miscellaneous Information

Have you ever been convicted of a felony?  Yes  No

Have you ever been involved in a malpractice suit?  Yes  No

Have you ever suffered from alcohol or drug dependence?  Yes  No

Have you ever suffered from mental or physical disabilities?  Yes  No

If you answered "Yes" to any of the above, please explain (attach additional pages if needed)

**18. Other activities and interests**

**19. REFERENCES**

**Three letters of reference from physicians or other professionals familiar with your work are required. Please have the letters sent directly to the program director.**

**Name**

**Address**

**Tel No.**

**Email:**

**Name**

**Address**

**Tel No.**

**Email:**

**Name**

**Address**

**Tel No.**

**Email:**

**I certify that the information provided in this application is accurate and complete to the best of my knowledge and understand that falsification of information will be sufficient grounds for refusal of appointment or dismissal.**

**Print Name**

**Signed \_\_\_\_\_ Date**

**Please mail the completed application, personal statement, Curriculum Vitae, and letters of recommendations to:**

**Sharon Dabrow, MD  
Professor of Pediatrics  
Director of the General Academic Pediatric Fellowship  
University of South Florida South Tampa Center  
2 Tampa General Circle-5<sup>th</sup> floor  
Tampa, FL 33606**

**GAP Fellowship/application/2010**