

Note: this application should be filled out online using the REDCap survey link provided. For completeness, this Word document is available in case REDCap is down for service.

Application for Medical Simulation Fellowship

Demographics:

Name:

Home Address:

Phone number(s):

Email address:

Training:

College (undergraduate education), year of graduation, degree:

Medical School (graduate education), year of graduation, degree:

Residency Program, year of graduation:

Fellowship Program (if applicable), year of graduation:

Other, please provide specifics:

Board Certification:

National Board, Flex or ECFMG; date:

Specialty Board, date:

Subspecialty Board, date:

Medical Licensure:

State, License number:

Honors and Awards:

Honors:

Awards:

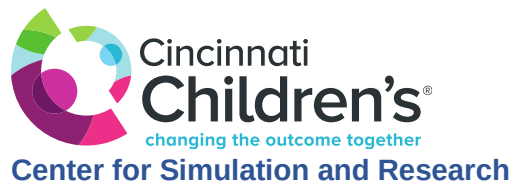
Medical Society Memberships:

Experience:

Please describe your past experience with simulation, including scenario development, course implementation and delivery, and academic productivity, if applicable

Personal Statement:

Please describe your future plans and interests that are specific to medical simulation



Curriculum Vitae and Letters of Recommendation:

A CV and two (2) letters of recommendation are required. CV and letters can be sent by standard mail or email addressed to: Gary L. Geis, MD, Program Director, Medical Simulation Fellowship, Center for Simulation and Research, Cincinnati Children's Hospital Medical Center, 3333 Burnet Avenue, ML 12000, Cincinnati, OH 45229-3039; email: Gary.Geis@cchmc.org

Attestation Statement:

I hereby apply for the position of Medical Simulation Fellow at the Center for Simulation and Research, Cincinnati Children's Hospital Medical Center beginning July 1, 2023 (or other agreed upon start date).

I understand that this fellowship is in collaboration with clinical work within the Department of Pediatrics at Cincinnati Children's Hospital Medical Center or similar academic pediatric medical center.

I certify that the facts and information provided by me on my application for Pediatric Emergency Medicine Clinical Staff (if applicable), on other application documents, and in my interviews are true and complete and I agree that if I receive an appointment, incorrect, incomplete or falsified information will be grounds for my dismissal, regardless of when discovered. I authorize Children's Hospital Medical Center to investigate all statements made herein or in my interviews and to obtain conviction records, make reference checks and obtain any other information relevant to my application, and I release Children's Hospital Medical Center and all other parties from any and all liability for any damages that may result from obtaining or furnishing such information.

I understand that I must successfully complete a physical evaluation conducted by Children's Hospital Medical Center at CHMC's expense. Additional expenses related to specialized testing or follow-up by my private physician will be my responsibility.

I agree to observe all present and subsequently issued personnel policies and procedures of Children's Hospital Medical Center.

I understand that Children's Hospital Medical Center maintains a drug-free workplace as required by the Drug-Free Workplace Act of 1988. I agree to submit to a drug screen prior to beginning my appointment with Children's Hospital Medical Center; I understand that I will not be considered for an appointment at Children's Hospital Medical Center if I fail to consent to testing, fail to authorize release of results or tamper with the results in any way. I understand that the unlawful manufacture, distribution, sale, possession, or use of controlled substances or illegal drugs is prohibited on Children's Hospital Medical Center time and in and on Children's Hospital Medical Center's owned or controlled property. I understand that in consideration of Children's Hospital Medical Center's patients, Children's Hospital Medical Center maintains a smoke-free workplace.

DATE _____ SIGNATURE _____