



**The Children's Mercy Hospitals and Clinics**  
**Application for Fellowship**  
Division: Gastroenterology, Hepatology & Nutrition  
(816) 234. 3016 Fax: (816) 855 1721 Email: [jdaniel@cmh.edu](mailto:jdaniel@cmh.edu).

Mail completed application to: James F. Daniel, MD, Fellowship Director  
The Children's Mercy Hospital & Clinics  
2401 Gillham Road  
Kansas City, Missouri 64108

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Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
*Last First Middle (Complete) Maiden (If Applicable)*  
Present Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Permanent Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Pager \_\_\_\_\_

Desired Starting Date of Appointment: \_\_\_\_\_ Are you a US citizen? Yes \_\_\_ No \_\_\_  
If no, Visa type: \_\_\_\_\_

Are you eligible or authorized to work in the US? Yes \_\_\_ No \_\_\_

**Education and Training**

College  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_ Major: \_\_\_\_\_ Degree: \_\_\_\_\_

Medical School  
Name: \_\_\_\_\_ Dates Attended: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_ Major: \_\_\_\_\_ Degree: \_\_\_\_\_

Internship  
Name: \_\_\_\_\_ Dates Attended: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_

Residency  
Name: \_\_\_\_\_ Dates Attended: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State: \_\_\_\_\_  
Dates Attended: \_\_\_\_\_

Fellowships, Other Special Training or Skills, Research Experience:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Honors and Awards:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Interests:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Military Service**

Were you in the U.S. Armed Forces? Yes \_\_\_ No \_\_\_ Branch: \_\_\_\_\_

Dates of Duty: From \_\_\_\_\_ To \_\_\_\_\_ Rank/Grade: \_\_\_\_\_

Medical Licensure: \_\_\_\_\_ States: \_\_\_\_\_

• Have you been or are you currently the subject of disciplinary proceedings by any State licensure agency? Yes \_\_\_ No \_\_\_

• Have you been or are you currently the subject of disciplinary proceedings by any hospital? Yes \_\_\_ No \_\_\_

*If you answered yes to either, please explain on an additional sheet and attach to this application.*

Flex: \_\_\_\_\_ State: \_\_\_\_\_ Date: \_\_\_\_\_ National Board No: \_\_\_\_\_ Part I: \_\_\_\_\_

Date: \_\_\_\_\_ Score: \_\_\_\_\_

Part II: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

Part III: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

E.C.F.M.G. (If Foreign Trained): \_\_\_\_\_ No.: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Members of Children’s Mercy Hospital & Clinics Faculty, Attending Staff or House Staff known by the applicant:

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

The following is required to support your application:

• Three letters of recommendation. A letter from the Chief of Staff, Chair of Pediatrics or Residency Director of the hospital(s) in which you obtained resident training and two letters of recommendation from physicians, preferably pediatricians/pediatric gastroenterologists.

• Current curriculum vitae.

• Personal statement that includes material relevant to qualification for fellowship and future plans.

• Transcript of grades from medical school.

Optional: A recent photograph.

*I certify that the facts and information I have provided on this application, on other pre-employment documents and during interviews are true and complete, and I agree that, if I receive an appointment, incorrect, incomplete or falsified information will be grounds for dismissal, regardless of when discovered.*

*I authorize The Children’s Mercy Hospital & Clinic 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 The Children’s Mercy Hospitals & Clinics and all other parties from any and all liability for any damages that may result from obtaining or furnishing such information.*

*I agree to observe all present and subsequently issued personnel policies and procedures of The Children’s Mercy Hospitals & Clinics.*

*I understand that The Children’s Mercy Hospitals & Clinics 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 The Children’s Mercy Hospital & Clinics. I understand that I will not be considered for an appointment at The Children’s Mercy Hospitals and Clinics 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 The Children’s Mercy Hospitals & Clinics time and in and on property owned or controlled by The Children’s Mercy Hospitals & Clinics.*

*I understand that I must obtain and maintain a valid permanent Missouri License. Fees required to obtain the license are my responsibility and not the responsibility of The Children’s Mercy Hospitals & Clinics. I understand that the institution’s liability insurance is available for residents during their employment at The Children’s Mercy Hospitals and Clinics.*

*I understand that I must submit to and successfully complete a criminal records background check prior to employment at The Children’s Mercy Hospitals & Clinics.*

*I understand that in consideration of the hospital’s patients, The Children’s Mercy Hospitals & Clinics will maintain a smoke-free workplace.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_