UT SOUTHWESTERN MEDICAL CENTER

Physical Medicine & Rehabilitation

Application for Fellowship

Pediatric Rehabilitation Medicine

Frank McDonald, MD
Physical Medicine & Rehabilitation
Children's Medical Center
1935 Medical District Dr
Dallas, Texas 75235
Office: 214-456-6783
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APPLICATION FOR FELLOWSHIP

POSITION BEGINNING IN_____
(Year)

NAME (LAST) (FIRST) (MIDDLE)	SOCIAL SECURITY NUMBER - -
PRESENT ADDRESS	ATTACH RECENT PHOTOGRAPH
(CITY) (STATE) (ZIP)	
PHONE . DAY ( ) EVENING ( )	
CITIZENSHIP _____ US _____ OTHER: _____ VISA STATUS (IF APPLICABLE) _____ PERMANENT _____ TEMPORARY – SPECIFY: ___ J-1 ___ H-1	
PERMANENT ADDRESS: C/O (NAME OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED)	
(CITY) (STATE) (ZIP)	PERMANENT PHONE NO. ( )

Are you legally eligible for employment in the United States (circle one)? YES NO

If No, please provide information: _____

1. Registered alien – Card # A_____
2. Non-Registered alien – Visa Type: _____ Expiration Date: ____/____/____

EDUCATION INFORMATION
(Please include Post-Doctoral Training)

Institution	City	State	Graduation Date	Degree

Please Circle Pass or Fail and provide information on the following:

USMLE Step I	USMLE Step II	USMLE Step III
PASS Score_____	PASS Score_____	PASS
FAIL Attempts_____	FAIL Attempts_____	FAIL

PROFESSIONAL LICENSES/CERTIFICATIONS

Registered _____ Certified _____ Licensed _____

Type: _____ **Date Issued:** _____ **Expiration Date:** _____ **Number & State:** ___

Registered _____ Certified _____ Licensed _____

Type: _____ **Date Issued:** _____ **Expiration Date:** _____ **Number & State:** ___

Noted Restrictions (circle one)? YES NO
If Yes, please specify:

_____

1. Have any legal claims or lawsuits been filed against you regarding patient care or treatment (circle one)? YES NO
2. Do you have any pending or threatened malpractice claims or lawsuits against you (circle one)? YES NO
3. Have any of the licenses or certifications identified in the previous section ever been revoked (circle one)? YES NO
4. Have you previously had hospital staff or other medical privileges revoked (circle one)? YES NO
5. Have you ever been placed on probation during residency (circle one)? YES NO

If you answered "Yes" to any of the above, please explain below (attach additional explanation if necessary): _____

_____

_____

_____

_____

SERVICE OBLIGATIONS (National Health Service Corps, Armed Forces Scholarship, State Programs, etc.)

_____ I am not required to fulfill any service obligations

_____ I am committed to fulfill a service obligation beginning _____
(MO./YR.)

Number of years committed _____

ACKNOWLEDGEMENT:

I ACKNOWLEDGE THE ABOVE ANSWERS AND ALL OTHER INFORMATION OTHERWISE GIVEN BY ME AS BEING TRUE, COMPLETE, AND NOT MISLEADING IN ANY WAY. I UNDERSTAND THAT ANY FALSE, INCOMPLETE, OR INCORRECT STATEMENTS FURNISHED BY ME CAN RESULT IN DISCHARGE. I AGREE TO COMPLY WITH ALL THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS REGULATIONS AND/OR POLICIES. I UNDERSTAND THAT UT SOUTHWESTERN MAY TERMINATE MY EMPLOYMENT AT ANY TIME FOR ANY REASON PURSUANT TO APPLICABLE POLICIES AND PROCEDURES OF THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS.

Signature of Applicant: _____ **Date**: _____

PLEASE INCLUDE THE FOLLOWING WITH THIS APPLICATION:

- **3 LETTERS OF RECOMMENDATION FROM YOUR CURRENT PROGRAM (ONE LETTER FROM YOUR CURRENT PROGRAM DIRECTOR & 2 LETTERS FROM OTHER FACULTY MEMBERS)**
  - **Letters of recommendation MUST be addressed to Frank McDonald, M.D. and mailed directly to Terri Isbell by the author of the letter.**
- **ORIGINAL MEDICAL SCHOOL TRANSCRIPTS**
- **USMLE TRANSCRIPTS**
- **COPY OF ALL STATE MEDICAL LICENSES CURRENTLY HELD**
- **COPY OF DEA REGISTRATION, TEXAS DPS REGISTRATION**
- **PERSONAL STATEMENT**

Please remit entire application and attachments to:

Terri Isbell
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UT Southwestern Medical Center at Dallas
5323 Harry Hines Blvd.
Dallas, Texas 75390-9055
214.648.8826
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