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| **Pediatric Hematology Oncology / Stem Cell Transplant Advanced Practice Provider Fellowship Program** | **Icon  Description automatically generated** |  |

**TEXAS CHILDREN’S CANCER AND HEMATOLOGY CENTER
 ADVANCED PRACTICE PROVIDER FELLOWSHIP APPLICATION**

**PLEASE SUBMIT THE COMPLETED APPLICATION, INCLUDING LETTERS OF RECOMMENDATION, IN 1 PDF FILE TO:**

Laura Sealy, DNP, CPNP-AC lesealy@texaschildrens.org

 Julie Klinger, PA-C jalerou1@texaschildrens.org

**APPLICANT INFORMATION**

|  |  |
| --- | --- |
| **Last Name First Name Middle**                  | **Present Address**      |
| **Home / Cell phone**      |  **Work phone**      | **Social Security Number**      |
| **Current Home Address**      | **Permanent Home Address (if different from Current Address)**      |
| **Are you a U.S. citizen?** [ ]  Yes [ ]  No**Will you need local housing information?** [ ]  Yes [ ]  NoWill you need local housing information? [ ]  Yes [ ]  No |

**EDUCATION**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Undergraduate Education**                     |  **Degree**           | **From (mm/yy)**           | **To (mm/yy)**           |
|  **Graduate Education**           |  **Degree**           | **From (mm/yy)**           | **To (mm/yy)**           |
|  **Other Degrees**           |  **Degree**           | **From (mm/yy)**           | **To (mm/yy)**           |

**EMPLOYMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital**       | **Title / Responsibilities**      | **From (mm/yy)**      | **To (mm/yy)**      |
| **Hospital**       | **Title / Responsibilities**      | **From (mm/yy)**      | **To (mm/yy)**      |
| **Hospital**       | **Title / Responsibilities**      | **From (mm/yy)**      | **To (mm/yy)**      |
| **Hospital**       | **Title / Responsibilities**      | **From (mm/yy)**      | **To (mm/yy)**      |

**PROFESSIONAL LICENSES/CERTIFICATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of License / State (if applicable)**      | **License #**      | **Date of Receipt (mm/yy)**       | **Date of Exp. (mm/yy)**      |
| **Type of Certification**      | **Cert. #**      | **Date of Certification**      | **If not, date of anticipated testing (mm/yy)**      |
| **Type of Certification**      | **Cert. #**      | **Date of Certification**      | **Date of Exp.**      |

**LIST MEMBERSHIP IN HONORARY OR PROFESSIONAL SOCIETIES, PRIZES, AWARDS, PUBLICATIONS**

**SKILLS/COMPETENCIES (Check all that apply)**

[ ]  Physical Exam

[ ]  History Taking

[ ]  Developmental Assessment

[ ]  Bone Marrow Aspiration

[ ]  Bone Marrow Biopsy

[ ]  Lumbar Puncture

[ ]  Intrathecal Chemotherapy Administration

[ ]  IV Starting

[ ]  Central line catheter care

[ ]  Chemotherapy administration and side effects

[ ]  Interpreting peripheral blood smears

[ ]  Teaching families and children about cancer and its treatment

[ ]  Understanding treatment protocols

[ ]  Managing side-effects of childhood cancer treatment

[ ]  Fundamentals of Hematopoietic Stem Cell Transplant

[ ]  HSCT treatment and side effects

[ ]  Anemias

[ ]  Thrombocytopenias and Coagulopathies

[ ]  Neutropenias

**COMMENTS**

**SUMMARIZE ANY WORK EXPERIENCE WITH CHILDREN WHO HAVE HAD CANCER, BLOOD DISORDERS OR A HEMATOPOEITIC STEM CELL TRANSPLANT. PLEASE DESCRIBE YOUR INTEREST IN THE FELLOWSHIP PROGRAM. PLEASE TYPE YOUR RESPONSE IN THE SPACE BELOW OR AS A SEPARATE PAGE.**

**REFERENCES**

|  |  |  |
| --- | --- | --- |
| **Name and Title** | **Email Address** | **Telephone** |
|       |       |       |
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|       |       |       |

Please provide the name and email addresses of professional colleagues, instructors or supervisors who are acquainted with your academic and professional experience.

**Which clinical experiences are you interested in? [Check 4 top interests]**

[ ]  Leukemia

[ ]  Lymphoma/Histiocytosis

[ ]  Hematology – Bone marrow failure

[ ]  Hemostasis / Thrombosis / Vascular anomalies

[ ]  Hematology – Sickle Cell

[ ]  Hematopoietic Stem Cell Transplantation

[ ]  Solid Tumors (bone tumors, liver tumors, retinoblastoma, rare tumors)

[ ]  Neuro Oncology (brain tumors, neuroblastoma)

[ ]  Developmental Therapeutics

[ ]  Long Term Survivor

[ ]  Other specialty interests:

**CHECKLIST**

Along with this application, please provide the following:

[ ]  Full CV

[ ]  3 Letters of Recommendation. Can be emailed to email address below.

I certify that the information submitted in this application is true, complete and accurate. I understand that any misrepresentation will be cause for denial of appointment. Application on line is acceptance of the disclaimer without signature.

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Applicant Signature Date

**Please submit this completed application, including letters of recommendation, in 1 PDF file to:**lesealy@texaschildrens.organd jalerou1@texaschildrens.org