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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](mailto:lesealy@texaschildrens.org)

Julie Klinger, PA-C [jalerou1@texaschildrens.org](mailto: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  No  Will 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.org](mailto:lesealy@texaschildrens.org)and [jalerou1@texaschildrens.org](mailto:jalerou1@texaschildrens.org)