

**University Hospitals Case Medical Center  
Post Pediatric Portal Training Program  
Applicant Checklist**

- Completed, signed, dated application
- Personal statement
- Current CV
- Letter of recommendation from your present training director if residency training was completed within the preceding 3 years
- 2 additional letters of recommendation specific to the Post Pediatric Portal Program from two attending physicians with whom you have worked (please include 1 additional letter if one is not completed by your training director)
- Copy of Medical School Diploma
- Medical School Transcripts (English translation for IMG's)
- Medical School Dean's Letter
- USMLE or COMLEX Transcript

**For Foreign Applicants**

- Current Visa Status
- ECFMG Certificate

Return all documents to: [Marquita.Moore@UHhospitals.org](mailto:Marquita.Moore@UHhospitals.org)

Marquita N. Moore  
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**University Hospitals Cleveland Medical Center**  
Application for Post Pediatric Portal Training Program  
Academic Year Beginning July 1, 2025

Applications should be typed or printed. Please include all items listed in the Application Checklist (final page of application) with your completed application. Following receipt of your completed application and checklist materials, you will be notified if a personal interview is requested.

Name:	Date of Birth:
Address (Home):	Email:
Phone (Day):	Phone (Evening):
Social Security#:	Citizenship:

Education and Post Graduate Training:

	School or Program	Location	Start Date	Graduation Date	Degree or Specialty
Undergraduate					
Medical School					
Internship					
Residency					
Other (if applicable)					

Post Residency Employment (if applicable):

Position	Location	Start Date	End Date	Reason for leaving

If additional space is needed, please document on separate sheet of paper and attach to application

Foreign Medical School Graduates only:

**Type of Visa:** \_\_\_\_\_ (University Hospitals requires a J-1 Visa).

Do you intend to apply for US citizenship?      **YES**                       **NO**

**ECFMG Certificate No:** \_\_\_\_\_

Attach copy of certificate or interim certificate and copy of scores. If you are now in the US, give date and

Port of Entry: \_\_\_\_\_

State or Professional Licensure:

State/Province	License Type	License #	License Status (indicate active or inactive)	Issue Date

Board Certification:

Name of Board	Certificate #	Issue Date

Examination History:

Examination	Date Taken (mm/yy)	Pass or Fail	Number of Attempts
USMLE Step 1			
USMLE Step 2 CK			
USMLE Step 2 CS			
USMLE Step 3			
COMLEX Level 1			
COMLEX Level 2 CE			
COMLEX Level 2 PE			
COMLEX Level 3			

Other:

- If there have been any interruptions in your training or employment, please describe the nature of the interruption on a separate sheet of paper.
- Do you require any special accommodations to perform the essential functions of a resident physician in the training program at University Hospitals of Cleveland?                       **NO**                       **YES**

If yes, please attach a separate sheet of paper explaining the required accommodation and how it would allow you to perform the essential functions of the position.

PHOTO – (optional) A recent photograph (black/white, passport size is not a requirement, but is very helpful.



**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_