PEDIATRIC ENVIRONMENTAL HEALTH and CLIMATE FELLOWSHIP APPLICATION

Application Deadline | October 1, 2026
Fellow Start Date | July 6, 2027

Profile

First Name:	
Middle Name:	
Last Name:	
Suffix:	
Previous Last Name:	
Contact Email:	
Date of Birth:	
Phone:	
Emergency Contact (Name and Number):	

Mailing Address

Street Address:	
City:	
State/Province:	
Zip/Postal Code:	

Citizenship

☐ US Citizen

☐ US Permanent Resident

☐ Other (Please list):

If you are a foreign national outside the US, or currently in the US on a valid visa status, please **respond to the questions below**. IF NOT A FOREIGN NATIONAL, SKIP TO THE SECTION LABELED "EDUCATION SECTION: General educational information" below the ECFMG/TOEFL scores.

Will you need a "visa sponsorship" through the teaching hospital (J1, H1B, etc.) to participate in US fellowship training? ☐ Yes ☐ No

NOTE: Fellows must obtain an appropriate, valid visa prior to commencement of training. Fellows themselves are responsible for any fees needed for visa applications, attorneys' fees, or other expenses incurred in the U.S. visa application process.

If yes to above:

- Please specify type of Visa:
- Did you train at a foreign medical school? ☐ Yes ☐ No
- Is your medical school listed on the approved list for state licenses to which you will be applying? ☐ Yes ☐ No ☐ Unsure*

**If you are unsure, please contact the programs to which you are applying. Obtaining state license, for the state in which you will be training, is mandatory to being fellowship.*

ECFMG/TOEFL Scores

Please provide documentation for your ECFMG and/or TOEFL scores in the space below.

EDUCATION SECTION: General Education Information

College/University:		From:		To:	
City, State:		Degree:			
Medical School:		From:		To:	
City, State:		Degree:			
Internship:		From:		To:	
City, State:		Degree:			
Residency:		From:		To:	
City, State:		Degree:			
Other Training:		From:		To:	
City, State:		Degree:			

1. Was your medical education/training extended or interrupted?

   ☐ Yes ☐ No

   If yes, please note the date and comment:

Licensure Information

This section allows entries for each of your state medical licenses.

Have you passed the USMLE Step 3? ☐ Yes ☐ No

☐ No current medical license (If you do not have a current medical license, skip to the "Board Certification" questions.)

Entry 1			
State:		License Number:	
License Type:		Expiration Month/Year:	
Entry 2			
State:		License Number:	
License Type:		Expiration Month/Year:	
DEA Number *(DEA is for US Medical License holders only.)*			
DEA Registration Number		Expiration Month/Year:	

1. Has your medical license ever been suspended / revoked/ voluntarily terminated?
   ☐ Yes ☐ No
   If yes, please note the date and comment:

2. Have you ever been named in a malpractice case? ☐ Yes ☐ No
   If yes, please note the date and comment:

3. Is there anything in your past history that would limit your ability to be licensed or would limit your ability to receive hospital privileges? ☐ Yes ☐ No
   If yes, please note the date and comment:

Board Certification

Are you Board Certified? ☐ Yes ☐ No
If no, will you be Board Eligible by the beginning of the fellowship? ☐ Yes ☐ No

Board Name:	

Are you Board Certified/eligible for more than one Board? ☐ Yes ☐ No
If no, will you be Board Eligible by the beginning of the fellowship? ☐ Yes ☐ No

Board Name:	

Miscellaneous

Are you able to carry out the responsibilities of a fellow in Pediatric Environmental Health and at the specific training program to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements, and attendance requirements with or without reasonable accommodations? ☐ Yes ☐ No
If no, please comment:

Letters of Recommendation

Please provide three letters of recommendation. If within 5 years of residency training, one of these letters must be from your residency program director or his or her designee. Your letter writers can address their letters to Dr. Marissa Hauptman and/or Dr. Alan Woolf. Please fill out the Confidential Reference Report for each of your recommenders and have them submit a Confidential Reference Report along with their letter of recommendation directly to the Program Coordinator listed below.

Reference 1

Name:	
Contact Information:	

Reference 2

Name:	
Contact Information:	

Reference 3

Name:	
Contact Information:	

Personal Statement

Please attach one page personal statement explaining why you want to do a fellowship in Academic General Pediatrics and/or Primary Care. Please include a description of your career goals, how the fellowship may assist you in achieving them, your scholarly/research interests, and how you envision your career five years after completion of this fellowship. You may want to include how past experiences have influenced your decision to apply and mention special areas of interest. *(Make sure your name appears on the attachment.)*

Attestation

I certify that the information contained in this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; or if employed, may constitute cause for termination from the program. I also understand and agree that the data included in this application may be shared within the fellowship programs to which I am applying.

☐ I agree with the attestation.

Name | Print

Name | Signature

Date

Checklist for Submission

- Email the following forms directly to the Fellowship Program Coordinator, Anna Schlemmer at Anna.Schlemmer@childrens.harvard.edu
    - Completed application form
    - Personal Statement
    - Updated CV
- Have the three (3) letters of recommendation and corresponding completed Confidential Reference Reports sent directly from the letter-writers to Fellowship Program Coordinator, Anna Schlemmer at Anna.Schlemmer@childrens.harvard.edu
    - As a reminder, one letter must be from your current Program Director.

DISCLOSURES AND ACKNOWLEDGEMENTS - Boston Children's Hospital is an Equal Opportunity Employer. Qualified applicants will receive consideration for employment without regard to their race, color, religion, national origin, sex, sexual orientation, gender identity, protected veteran status or disability.

LIE DETECTOR TEST - It is unlawful in Massachusetts to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law shall be subject to criminal penalties and civil liability. Boston Children's Hospital does not administer lie detector tests as a condition of employment or continued employment.

By submitting my application, I confirm and acknowledge the following:

- The information provided by me on this application is true, accurate and complete. I understand that if Boston Children's Hospital becomes aware that I have provided incorrect, false or misleading information or made material omissions of fact during the application process, Boston Children's Hospital may disqualify me from further consideration for employment, withdraw my job offer, refuse employment or take disciplinary action, including dismissal.
- If I am applying for a position that requires licensure and/or certification, I have or will have such licensure and/or certification by the time I start.
- This application carries no promise of employment.
- Any offer of employment will be conditioned upon satisfactory and complete education and reference checks. Boston Children's Hospital has authority to contact the educational institutions identified by me on this application and/or on my resume to confirm the accuracy of the information which I have provided. Boston Children's Hospital has authority to contact the references I provide and the supervisors identified as contactable in this application, to make all inquiries appropriate and necessary to ensure thorough reference checks (including but not limited to inquiring about duties, responsibilities, reason for leaving, employment history and other qualifications for employment), and I release Boston Children's Hospital from any liability in connection with these reference checks.
- Employment at Boston Children's Hospital is conditioned upon completion and review of a Criminal Offender Record Information (CORI) check.
- If hired, I will provide no later than my first day of hire proof of my identity and valid proof of legal work authorization in accordance with federal law. I understand that I will not be permitted to begin work until such proof is furnished.