QUEEN SIRIKIT NATIONAL INSTITUTE of CHILD HEALTH

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Email: irqsnich@gmail.com

FELLOWSHIP APPLICATION FORM

(I) TYPE OF PROGRAMME	
Discipline	
Programme Name	
Sponsorship	☐ Sponsored by your hospital/self/third parties ☐ Not sponsored
Period of Training	☐ 3 months ☐ 6 months ☐ 1 year ☐ others
If others, please specify:	
With Hands-On	
State Training Objectives (max 500 characters)	

(II) PARTICULARS OF APPLICANT		
Full Name as shown in ID Card / Passport		
Contact Number		Email:
Identity Card / Passport Number		Sex: ☐ Male ☐ Female
Date of Birth		Marital Status:

(III) QUALIFICATIONS OF APPLICANT

Undergraduate Medical Qualifications

Category	Institution	Country	Date of Joining	Date of Completion	Qualification Attained	Year Attained
Pre-Medical Degree (where applicable)						
Undergraduate Medical Degree						
Details of Undergraduate Medical Degree	If you DID NOT complete your undergraduate medical degree in the SAME university, please check below box and complete the following section. ☐ Did Not Complete Degree in the Same University					
First Year						
Second Year						
Third Year						
Fourth Year						
Fifth Year						
Sixth Year						

Postgraduate Medical Qualifications

Postgraduate Qualification	Conferring Institution	Country	Specialty	Year
1.				
2.				
3.				
4.				
5.				
Was your medical training conducted in English? ☐ Yes ☐ No				
TOEFL score (if any)				
IELTS score (if any)				

(IV) WORK EXPERIENCE OF APPLICANT

Internship / Housemanship Experience

Discipline	Date of Joining	Date of Completion	Institution	Country
1.				
2.				
3.				
4.				
5.				

Appointment

Please list in chronological order from the most recent appointment:

Position Held	Date of Joining	Date of Completion	Department / Institution	Country
1.				
2.				
3.				
4.				
5.				

(V) REFEREES

Particulars of 2 referees who are at least of consultant grade and members of the academy of medicine or recognized foreign academic / professional organizations.

First Referee	
Name	
Occupation and Designation	
Name and Place of Employment	
Contact Number	
Email	
Facsimile Number	
In What Capacity Do You Know Him/Her	
Number of Years You Know Him/Her	
Second Referee	
Name	
Occupation and Designation	
Name and Place of Employment	
Contact Number	
Email	
Facsimile Number	
In What Capacity Do You Know Him/Her	
Number of Years You Know Him/Her	

(VI) DECLARATION BY APPLICANT

Have you ever been or are you currently the subject of an inquiry or an investigation by any licensing or health authority involving an allegation of professional misconduct or any improper conduct which brings disrepute to the medical profession?	☐ Yes ☐ No
If yes, please specify reason(s):	
Have you ever suffered or are you suffering from any physical or mental illness which impairs your fitness to practice as a medical practitioner?	☐ Yes ☐ No
If yes, please specify reason(s):	
Are you a hepatitis B carrier?	☐ Yes ☐ No
Have you ever been convicted in a court of law in your country or elsewhere of any offence?	☐ Yes ☐ No
If yes, please specify reason(s):	

I declare that the information I am submitting are true and complete to the best of my knowledge, and that I have not willfully suppressed any material fact.

Please include a current copy of your *Curriculum Vitae and score transcripts* (copies acceptable). Score transcripts may be submitted after your application has been submitted, but must be received in order for your application to be completed.

Signature ..... *Date* .....