

**Academic General Pediatrics Fellowship Programs - Common Application
Nemours Children’s Hospital, Delaware GAP Fellowship
Accreditation: Academic Pediatric Association**

Application Due Date: Sept. 1, 2025; Start Date: Jul. 1, 2026

Nemours Application Checklist:

Please email the following materials to Clara Greskoff, Program Coordinator: clara.greskoff@nemours.org by 11:59 pm EST on Sept. 1, 2025:

- This application form, completed and signed
- A 1-page personal statement
- A current curriculum vitae (CV)
- In addition, please request 3 letters of recommendation (if you are within 5 years of residency, one should be from your residency program director or their designee). Letters should be accompanied by a [confidential reference report](#). Letters should be emailed directly to Clara Greskoff, Program Coordinator (clara.greskoff@nemours.org) by the referees.

Please register for the Pediatric Fellowship Fall Specialties NRMP Match using the following link: <https://r3.nrmp.org/viewLoginPage>

Questions? Please reach out to Clara Greskoff, Program Coordinator (clara.greskoff@nemours.org).

I. PERSONAL INFORMATION

Last Name:
First Name:
Middle Initial:
Suffix:
Previous Names:

(Optional) Date of Birth (MM/DD/YYYY): ___/___/_____

Email:
Phone/SMS:
Emergency Contact Name:
Emergency Contact Phone:
Mailing Address
Street Address:
City:
State:
Zip/Postal Code:

Citizenship (Choose one):

- US Citizen
- US Permanent Resident
- Other (please specify):

II. EDUCATION AND TRAINING

	Name of Institution	From (MM/YYYY)	To (MM/YYYY)
College/University			
City, State		Degree:	
Medical School			
City, State		Degree:	
Internship			
City, State		Degree (if any):	
Residency			
City, State		Degree (if any):	
Other Training			
City, State		Degree (if any):	

ECFMG/TOEFL Scores

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

Was your medical education/training extended or interrupted? Yes No

→If YES, please note the date and comment:

III. LICENSURE INFORMATION

This section allows entries for each of your state medical licenses. If you do not have a medical license, skip to Section IV.

Have you passed USMLE Step 3? Yes No

Current Medical License(s)

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:

Has your medical license ever been suspended, revoked, or voluntarily terminated? Yes No

→If YES, please note the date and comment:

Have you ever been named in a malpractice case? Yes No

→If YES, please note the date and comment:

Is there anything in your personal or professional 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:

IV. BOARD CERTIFICATION

Are you Board Certified? Yes No

→If YES, Board Name: _____

→If NO, will you be Board Eligible by the beginning of the fellowship? Yes No

Are you Board Certified/eligible for more than one Board? Yes No

→If YES, will you be eligible for a second Board by the beginning of the fellowship? Yes No

Second Board Name: _____

V. MISCELLANEOUS

Are you able to carry out the responsibilities of a fellow in Academic General Pediatrics 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 explain:

VI. LETTERS OF RECOMMENDATION

Please provide three (3) letters of recommendation. If you are within five years of residency training, one letter must be from your Residency Program Director or their designee. Make sure each letter writer receives a [Confidential Reference Report](#). A report must be submitted alongside each letter of recommendation. Letter writers should submit their letters of recommendation along with a Confidential Reference Report via email **directly** to the Fellowship Program Coordinator.

Reference 1	
Name:	Address:
Title:	Email:
Institution:	Phone:
Reference 2	
Name:	Address:
Title:	Email:
Institution:	Phone:
Reference 3	
Name:	Address:
Title:	Email:
Institution:	Phone:

VII. PERSONAL STATEMENT

Please attach a one-page personal statement explaining why you want to complete a fellowship in Academic General Pediatrics. Please include the following: 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. *(Please include your name on the attachment.)*

VIII. CURRICULUM VITAE

Please attached a current curriculum vitae.

IV. 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 above attestation.

Signature

Date (MM/DD/YYYY)