Application for Fellowship

Subspecialty Program _____

Starting Date _____

NAME_____ DATE OF BIRTH_____
last first middle

ADDRESS_____ TELEPHONE (HOME)_____

_____ TELEPHONE (WORK)_____

EMAIL _____ PAGER # _____

CITIZENSHIP_____

VISA Type (J1, H1, F1, etc.)_____Expiration date:_____Permanent Resident ?_____Other_____
(proof of visa status must accompany application)

EDUCATION:

PREMEDICAL COLLEGE_____DEGREE _____YEAR COMPLETED_____

MEDICAL SCHOOL_____DEGREE_____YEAR COMPLETED_____

If foreign trained, have you taken:

ECFMG EXAM_____where_____date_____certificate no_____

USMLE or LMCC exam_____where_____date _____results_____
(copies of ECFMG and USMLE must be included)

AMERICAN BOARD of RADIOLOGY EXAMS

Physics_____ Written_____ Oral_____
(dates taken and results)

STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE

STATE _____ License # _____ Expiration Date _____

Have you ever been denied or lost a state license? If yes explain why.

TRAINING:

1st Post Graduate Year (Internship):

Hospital _____type of training _____dates_____

Other education, training or hospital research :
(please list in chronological order, including your present position)

Institution _____
name address type of training dates

_____

_____

REFERENCES: please list the names and institutions of three physicians who will be writing letters for you

_____

_____

_____

Date _____(Signed)_____

Please send this cover sheet with a copy of your CV and a personal statement to the fellowship director at the address specified by the program. One of the letters c recommendation must be from your program director. Please note some programs, in addition, require copies of your Dean's letter, USMLE transcript and/or proof c graduation from medical school.