

Application for Fellowship

Subspecialty Program _____

Starting Date _____

NAME _____
last first middle

DATE OF BIRTH _____

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 of 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 of graduation from medical school.