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 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 graduation from medical school.