University Hospitals Cleveland Medical Center, Department of Radiology

Application for Fellowship Starting: 07/01/

SUBSPECIALTY PROGRAM ____________________

Please type all responses or mark "N/A" if it does not pertain to you. Please do not leave any sections blank.

CONTACT INFORMATION

Last Name ____________ First Name ____________ M.I. ______

Date of Birth ____________ Place of Birth ____________

Address ____________ SSN ____________

Phone ____________ Email ____________

Citizenship ____________ VISA Type (J1, H1, F1, etc.) ____________

Entrance Date ________ Expiration Date ________ Permanent Residence ________

EDUCATION

Premed College ____________ Degree ____________ Year Completed ______

Medical School ____________ Degree ____________ Year Completed ______

USMLE Exam Step 1 ________ Step 2 ________ Step 3 ________

ECFMG Exam (if applicable)

Where ____________ Date ________ Certificate # ________

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

Hospital ____________ Type of Training ____________ Dates ______

Radiology Residency

Institution ____________ Type of Training ____________ Dates ______

Other training or fellowship

____

Please explain any gaps, one month or longer, in clinical training and/or appointments since receipt of degree.

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REFERENCES

Please list the names, institutions, and contact information of three physicians who will be writing letters for you. One of the letters of recommendation must be from your program director.

FIRST REFERENCE	SECOND REFERENCE	THIRD REFERENCE
Name ________	Name ________	Name ________
Institution ________	Institution ________	Institution ________
Email ________	Email ________	Email ________
Phone ________	Phone ________	Phone ________

I certify that all information submitted by me in this application is true to the best of my knowledge and belief.

Date ____________ Printed Name ____________________