

# Application for University of Washington Nuclear Medicine Residency Training

## INSTRUCTIONS

The completed form should be returned to: David Lewis, M.D., Division of Nuclear Medicine, University of Washington Medical Center, 1959 N.E. Pacific St., Box 356113, Seattle, WA 98195-6113.

TYPE OF APPLICATION: Residency  1 year  2 year  3 year program

Date \_\_\_\_\_ Date you wish to begin training \_\_\_\_\_

Full name \_\_\_\_\_

Date of birth \_\_\_\_\_

Citizenship \_\_\_\_\_

Business address \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_ Phone \_\_\_\_\_

## PREMEDICAL EDUCATION

College	Address	Date: From-To	Degree
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## MEDICAL EDUCATION

College	Address	Date: From-To	Degree
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS

Position	City	Institution	Type of service	Date From-To
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

USMLE Step 1: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Step 2 CK: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Step 2 CS: Pass / Fail Step 3: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

ARE YOU LICENSED TO PRACTICE MEDICINE? \_\_\_\_\_ Where? \_\_\_\_\_

MILITARY SERVICE AND PRESENT STATUS \_\_\_\_\_

Board Eligibility \_\_\_\_\_

• ECFMG status or other qualifications \_\_\_\_\_

• Visa type \_\_\_\_\_ Visa number \_\_\_\_\_ Visa expiration \_\_\_\_\_

HONORS, SCHOLARSHIPS, GRANTS \_\_\_\_\_

MEMBERSHIP IN PROFESSIONAL SOCIETIES \_\_\_\_\_

PUBLICATIONS \_\_\_\_\_

#### SPECIAL TRAINING AND INTERESTS

• Have you had any special training or experience in the basic science or clinical aspects of nuclear medicine? If so, please describe:

YES answers to the following questions require a written explanation on a separate sheet (positive responses to questions do not necessarily preclude acceptance).

Have you ever been involved in a malpractice lawsuit or claim (whether or not you were individually named as a defendant)? Yes No

Have you ever been called before any entity for questioning concerning unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment? Yes No

If you have been licensed to practice medicine, has any such license, or application for it, ever been denied, revoked, suspended, or restricted? Yes No

Have you ever been addicted to, or treated for addiction to, a controlled substance drug, or chemical? Yes No

Have you ever used a prescription drug, including controlled substances, for other than therapeutic purposes? Yes No

Are you currently suffering from any disability or illness (mental or physical) that could affect your ability to fully practice medicine? Yes No

- **On a separate sheet write a personal statement listing your reasons for selecting nuclear medicine, your long-range objectives in nuclear medicine, and the amount and type of training you desire.**
- Where do you contemplate locating after your training? \_\_\_\_\_
- Upon completion of the program, you intend to receive (check all that apply):
  - ABNM certification by examination
  - ABR Nuclear Radiology Special Competency by examination

REFERENCES

- Please ask the dean of the medical school from which you graduated to send a letter of characterization, including your rank in your graduating class (Dean’s letter).
- List a minimum of three additional references. Include the director of your internship or residency program (please contact them and ask each to write a letter of reference at this time).

Name	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date