

**APPLICATION FOR FELLOWSHIP TRAINING
UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON**



**HARBORVIEW
MEDICAL CENTER**
DEPARTMENT OF RADIOLOGY

INSTRUCTIONS (Please Type)

The completed typed form should be returned ASAP to:

Emergency Radiology Fellowship Program Coordinator, eradpc@uw.edu

If you need more space, please attach additional pages with the appropriate printed (not handwritten) information.

Type of fellowship training desired: **EMERGENCY RADIOLOGY**

Date of Application _____ Date you wish to begin training _____

Name _____
(last) (first) (middle)

Date of birth _____

Home address _____

Business address _____

Cell phone _____ Home phone _____ Business phone _____

PREMEDICAL EDUCATION

College	Address	Date: From-To	Degree

MEDICAL EDUCATION

College	Address	Date: From-To	Degree

POSTGRADUATE TRAINING

Position	City	Institution	Type of service	Date From-To

Did you graduate from your Radiology Residency Program? Yes No

FOREIGN MEDICAL GRADUATES

ECFMG status or other qualifications _____

USMLE status _____

Passed USMLE? Step 1: Yes No Step 2: Yes No Step 3: Yes No

Visa type _____ Visa number _____ Visa expiration _____

ARE YOU LICENSED TO PRACTICE MEDICINE? Yes No Where? _____

MILITARY SERVICE AND PRESENT STATUS _____

WHAT IS YOUR AMERICAN BOARD OF RADIOLOGY STATUS? _____

HONORS, SCHOLARSHIPS, GRANTS _____

PUBLICATIONS _____

SPECIAL TRAINING AND INTERESTS

Have you had any special training or experience that could contribute to a research project during your training?

YES ANSWERS TO THE FOLLOWING QUESTIONS REQUIRE A WRITTEN EXPLANATION ON A SEPARATE SHEET

(Yes answers 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

PERSONAL STATEMENT: On a separate sheet narrate your reasons for seeking fellowship training, your long range objectives in radiology and the amount and type of subsequent training you desire.

AFTER YOUR TRAINING, where do you contemplate locating? _____

REFERENCES

List a minimum of three additional references.

Name Title Address

SIGNATURE

DATE