

# APPLICATION FOR FELLOWSHIP TRAINING

UNIVERSITY OF WASHINGTON  
SEATTLE, WASHINGTON

## INSTRUCTIONS (Please Type)

The completed **typed** form should be returned ASAP to: Body Imaging of Cancer Fellowship Program, Department of Radiology, University of Washington, 1959 N.E. Pacific Street, Box 357115, Seattle, Washington 98195-7115.

Type of fellowship training desired: BODY IMAGING OF CANCER

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

Name: \_\_\_\_\_  
(last) (first) (middle)

Do you have a US Social Security number? Yes\_\_\_ No\_\_\_ Date of Birth: \_\_\_\_\_

Business Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Email Address: \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ Home 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 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- The University of Washington provides equal opportunity in education on the basis of race, color, national origin and sex in accordance with Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments and Sections 799A and 855 of the Public Health Service Act.

**FOREIGN MEDICAL GRADUATES** - Please complete the following three items:

- ECFMG status and number \_\_\_\_\_
- USMLE status \_\_\_\_\_
- Current or Prior U.S. Visa types & dates \_\_\_\_\_

**WHAT IS YOUR AMERICAN BOARD OF RADIOLOGY STATUS?** \_\_\_\_\_

**ARE YOU LICENSED TO PRACTICE MEDICINE?** \_\_\_\_\_ Where? \_\_\_\_\_ License Number: \_\_\_\_\_

Note: This fellowship requires **eligibility** for a full Washington medical license.

**MILITARY STATUS:** \_\_\_\_\_

Are you currently suffering from any disability or illness (mental or physical) which could affect your ability to fully practice medicine?

\_\_\_\_\_

**HONORS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PUBLICATIONS LIST:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SPECIAL TRAINING AND INTERESTS:**

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

\_\_\_\_\_

\_\_\_\_\_

- 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.
- Please mail or e-mail a current copy of your **curriculum vitae**.
- Where do you contemplate locating after your training? \_\_\_\_\_

**REFERENCES**

• **List three references.** Include the Director of your residency program. (Please contact them and ask each to write a letter of reference at this time.)

| Name  | Title | Address |
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**Signature**

**(Date)**