

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE



Department of Radiology
APPLICATION FOR FELLOWSHIP TRAINING

Type of Fellowship Training Desired: Please return completed application packet to the address indicated

Abdominal (Body) Imaging: Mariam Moshiri, MD
BI Fellowship Director
UW Department of Radiology
Box 357115
1959 NE Pacific Street
Seattle, WA 98195-7115

Cardiac MR: Jeff Maki, MD
MR Fellowship Director
UW Department of Radiology
Box 357115
1959 NE Pacific Street
Seattle, WA 98195-7115

Date of Application _____ Date you wish to begin training _____
(Last) (First) (Middle Initial)
Name _____

Date of Birth _____ Place of Birth _____
Do you have a US Social Security number? ___ Yes ___ No
Citizenship _____

Business Address _____ Home Address _____

Telephone _____ Telephone _____

E-mail Address _____ E-mail Address _____

PREMEDICAL EDUCATION:

(College Name) (Address) (Date From-To) (Degree)

MEDICAL EDUCATION:

(College Name) (Address) (Date From-To) (Degree)

TEST RESULTS: (double click check box to check.)

USMLE 1: Pass Fail LMCC 1: Pass Fail

USMLE 2: Pass Fail LMCC 2: Pass Fail

USMLE 3: Pass Fail

POSTGRADUATE TRAINING:

(Position)

(City)

(Institution)

(Type of Service)

(Date From-To)

OTHER INFORMATION:

WHAT IS YOUR AMERICAN BOARD OF RADIOLOGY

STATUS? _____

ARE YOU LICENSED TO PRACTICE MEDICINE? _____ Where? _____ License # _____

MILITARY STATUS _____

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

Yes__ No__ If yes, please describe: _____

HONORS _____

PUBLICATIONS _____

FOREIGN MEDICAL GRADUATES - Please complete the following items:

- ECFMG Status and **Number** _____
- USMLE Status _____
- Current or Prior U.S. Visa Types & Dates _____

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 include a current copy of your **curriculum vitae**.
- Where do you contemplate locating after your training? _____

REFERENCES:

- **List three references**, including the director of your residency program

(Name)

(Title)

(Address)

Signature

Date