

**APPLICATION FOR FELLOWSHIP TRAINING:
Breast Imaging Section, Dept. of Radiology**

**UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON**

INSTRUCTIONS (Please Type)

The completed **typed** form should be returned ASAP to: Breast Imaging Fellowship Coordinator, Seattle Cancer Care Alliance, 825 Eastlake Avenue East, G3-200, Seattle WA 98109-1023. Please call the Fellowship Coordinator at (206)288-6241 with any questions.

Type of fellowship training desired: BREAST IMAGING

Date of Application _____ Date you wish to begin training: _____

Name: _____
(Last) (First) (Middle)

Social Security No.: _____ Date of Birth: _____

Business Address: _____ Home Address: _____

Email Address: _____

Business Phone: () _____ Home Phone: () _____

NATIONAL RESIDENCY MATCH PROGRAM (NRMP) APPLICANT#: _____

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 two items:

- ECFMG status and number _____
- Visa no. _____

WHAT IS YOUR AMERICAN BOARD OF RADIOLOGY STATUS? _____

ARE YOU LICENSED TO PRACTICE MEDICINE? _____ Where? _____ License Number: _____

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

Signature (Date)