Application for Fellowship

Breast Imaging

NAME_____ DATE OF BIRTH_____
Last First Middle

ADDRESS _____TELEPHONE (HOME)_____

TELEPHONE (WORK)_____

EMAIL _____

EDUCATION:

PREMEDICAL COLLEGE _____DEGREE _____ YEAR COMPLETED _____

MEDICAL SCHOOL _____DEGREE _____YEAR COMPLETED _____

USMLE STEP III – PASSED_____

WHERE _____DATE _____ CERTIFICATE NO. _____

AMERICAN BOARD OF RADIOLOGY EXAMS

PHYSICS _____WRITTEN _____ ORAL _____
(Dates taken and results)

STATE _____ LICENSE # _____ EXPIRATION DATE _____

Have you ever been denied or lost a state license? If yes, explain why.

TRAINING:

1ST POST GRADUATE YEAR (Internship)

Hospital _____Type of training _____ Dates _____

Other education, training or hospital research:
(Please list in chronological order, including your present position.)

Institution _____
Name Address Type of Training Dates

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Name Address Type of Training Dates

LETTERS OF RECOMMENDATION: Three letters of recommendation are required with one from your Program Director verifying standing in residency program. Please list below:

_____
_____
_____

Please include:

- Passport size photo
- Medical school transcript
- Current CV
- Personal statement including career goals and professional plans.
- USMLE scores

Date _____ (Signed) _____