UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

Department of Radiology – Abdominal Radiology

# APPLICATION FOR ACGME FELLOWSHIP TRAINING

Name _____ _____ _____
(Last) (First) (Middle Initial)

Date of Birth _____ Place of Birth _____

Do you have a US Social Security number? ____Yes ____No Citizenship _____

Business Address _____ Home Address _____

_____ _____

BusinessTelephone _____ Home 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?

- Please include a current copy of your **curriculum vitae**.
- Please send a copy of your **medical school diploma.**
- 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.

**REFERENCES:**

- **List three references,** including the director of your residency program. Letters of reference must be sent directly from their writers to our program (address given below).

(Name) (Title) (Email Address)

**Signature** Date

**Please email completed application packet in PDF form to:** fellowbi@uw.edu.

Mailing Address:
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UW Department of Radiology
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Seattle, WA 98195-7115