Application for University of Washington Nuclear Medicine Fellowship Training

INSTRUCTIONS
The completed form should be returned to: Hubert Vesselle, Ph.D., M.D., Division of Nuclear Medicine, University of Washington Medical Center, 1959 N.E. Pacific St., Box 357115, Seattle, WA 98195-7115.

TYPE OF APPLICATION: ☐ PET/CT Fellowship (1 year)

☐ Interested in Hybrid-Imaging Fellowship program (2nd year at discretion of the director)

Date__________________________ Date you wish to begin training____

Full name____

Date of birth____Email address:______________________________

Citizenship__________________________________

Business address____Phone_______________________________

Home address____Phone______________________________

PREMEDICAL EDUCATION

College	Address	Date: From-To	Degree

MEDICAL EDUCATION

College	Address	Date: From-To	Degree

INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS

Position	City	Institution	Type of service	Date From-To

USMLE Step 1: ______/______ Step 2 CK: ______/______ Step 2 CS: Pass / Fail (if taken prior to 5/26/2020) Step 3: ______/______ OET exam: (in lieu of USMLE Step 2 CS, after 5/26/2020) ___________

ARE YOU LICENSED TO PRACTICE MEDICINE?______________Where?____

MILITARY SERVICE AND PRESENT STATUS____

Board Eligibility____

• ECFMG status or other qualifications____

• Visa type___________________________ Visa number________________________________ Visa expiration _______________

HONORS, SCHOLARSHIPS, GRANTS____

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MEMBERSHIP IN PROFESSIONAL SOCIETIES____

PUBLICATIONS____

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SPECIAL TRAINING AND INTERESTS

• Have you had any special training or experience in the basic science or clinical aspects of nuclear medicine? If so, please describe (attach additional page if needed):

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YES answers to the following questions require a written explanation on a separate sheet.

- Positive responses to questions do not necessarily preclude acceptance.

Have you ever been involved in a malpractice lawsuit or claim (whether or not you were individually named as a defendant)?	Yes	No
Have you ever been called before any entity for questioning concerning unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment?	Yes	No
If you have been licensed to practice medicine, has any such license, or application for it, ever been denied, revoked, suspended, or restricted?	Yes	No
Have you ever been addicted to, or treated for addiction to, a controlled substance, drug, or chemical?	Yes	No
Have you ever used a prescription drug, including controlled substances, for other than therapeutic purposes?	Yes	No
Are you currently suffering from any disability or illness (mental or physical) that could affect your ability to fully practice medicine?	Yes	No

On a separate sheet write a note listing your reasons for selecting nuclear medicine, your long-range objectives in nuclear medicine, and the amount and type of training you desire.

Where do you contemplate locating after your training? ____

Upon completion of the program, you intend to receive (check all that apply):

☐ABNM certification by examination
☐ABR Nuclear Radiology Special Competency by examination

REFERENCES

• Please ask the dean of the medical school from which you graduated to send a letter of characterization, including your rank in your graduating class (Dean's letter).

• List a minimum of three additional references. Include the director of your internship or residency program (please contact them and ask each to write a letter of reference at this time). Letters of Recommendation should be current.

Name	Title	Address

____ ____________

Applicant's Signature Date