**Application for the University of Washington Cardiothoracic Imaging Fellowship Program**

**WE ACCEPT TYPED APPLICATIONS ONLY. HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED**

The completed form should be returned to Kathy Nguyen at kn38@uw.edu

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| **Desired academic year to begin training:** |  |
| **Full name:** |  |
| **Date of birth:** |  |
| **Citizenship:** |  |
| **Business address and phone number:** |  |
| **Home address and phone number:** |  |
| **Email address:** |  |
| **PREMEDICAL EDUCATION** |
| **College:** | **Address:** | **Date (from-to):** | **Degree:** |
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|  |  |  |  |
| **MEDICAL EDUCATION** |
| **College:** | **Address:** | **Date (from-to):** | **Degree** |
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| **INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS** |
| **Position:** | **Location:** | **Institution name:** | **Type of service:** | **Date (from-to):** |
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| **USMLE Scores** |
| **Step 1** [ ] Pass [ ] Fail | **Step 2:** | **Step 3:** |
| Are you licensed to practice medicine? If so, where? |
| Military service and present status: |
| **Board Eligibility** |
| ECFMG status or other qualifications: |
| **Visa type, visa number, and visa expiration (if applicable):** |  |
| **Honors, Scholarships, and Grants** |
|  |
| **Membership in Professional Societies** |
|  |
| **Publications** |
|  |
| **Special Training and Interests**  |
| Have you had any special training or experience that could contribute to a research project during your training? If so, please describe: |
| **YES answers to any of the following questions require a written explanation on a separate sheet (positive responses to questions do not necessarily preclude acceptance):** | **YES** | **NO** |
| Have you ever been involved in a malpractice lawsuit or claim (whether or not you were individually named as a defendant)? |  |  |
| Have you ever been called before any entity for questioning concerning unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment? |  |  |
| If you have been licensed to practice medicine, has any such license, or application for it, ever been denied, revoked, suspended or restricted? |  |  |
| Have you ever been addicted to, or treated for addiction to, a controlled substance, drug, or chemical?  |  |  |
| Have you ever used a prescription drug, including controlled substances, for other than therapeutic purposes?  |  |  |
| Are you currently suffering from any disability or illness (mental or physical) that could affect your ability to fully practice medicine?  |  |  |
| **Please narrate your reasons for seeking fellowship training, your long-range objectives and the amount and type of subsequent training you desire. Where do you contemplate locating after your training?** |
|  |
| **References. We require 3 letters of recommendation including a letter from your residency training program, a letter from your current fellowship (if attending), and a letter from other faculty, colleagues, or fellowship directors** |
| **Name:** | **Title:** | **Address:** |
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| **Signature:** | **Date:** |