Application for the University of Washington 4-Year ABR Alternate Pathway

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

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

Date you wish to begin training:			
Full name:			
Date of birth:			
Citizenship:			
Business address:		**Phone:**	
Home address:		**Phone:**	
Email address:			
PREMEDICAL EDUCATION			
College:	**Address:**	**Date (from-to):**	**Degree:**
MEDICAL EDUCATION			
College:	**Address:**	**Date (from-to):**	**Degree**

INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS				
Position:	**Location:**	**Institution name:**	**Type of service:**	**Date (from-to):**

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:**	**Visa expiration:**

Honors, Scholarships, and Grants

Membership in Professional Societies

Publications (Include additional publications on another page or in your CV if more space is needed)

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:			
Which following programs would you most prefer to have as part of your pathway? We will attempt to offer a 4-year pathway that meets this as much as possible. However, our training positions are limited and you may be offered a 4-year pathway different from your initial request.	☐Abdominal Radiology ☐Cancer Imaging ☐Cardiothoracic Imaging ☐Emergency Radiology ☐Musculoskeletal Radiology ☐Neuroradiology ☐Nuclear Medicine ☐PET/CT ☐Pediatric Radiology		
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. MUST include institutional emails, such as ones ending in .edu or .org, etc. (No personal emails please, such as ones ending in @yahoo or @gmail, etc.)	
Name, title, email, phone number (optional), and specify the date range when you worked with this reference:	
Name, title, email, phone number (optional), and specify the date range when you worked with this reference:	
Name, title, email, phone number (optional), and specify the date range when you worked with this reference:	
Signature:	**Date:**

CLINICAL EXPERIENCE QUESTIONNAIRE

CT EXPERIENCE:

1. What type of CT scanner do you have the most experience with? Mark all that apply.

64 slice MDCT	
256 slice or newer generation MDCT	
Dual energy	
Dual source	
Revolution (GE) or similar	
Others	
None	

2. On average, how many CT exams do you read per day?

3. Do you have experience with the following types of CT examination? Mark all that apply in the middle column and state how many cases per month you are exposed to.

CT Type		**Number of cases per month**
CT angiography (CTA of chest or abd or pel including PE studies)		
Multiphase CT of liver		
Multiphase CT of pancreas		
Routine CT Abd/Pel		
CT IVP		
CT chest		
CTA coronary or cardiac		

4. How often do you protocol CT examinations in your practice?

Additional comments:

MRI EXPERIENCE:

1. What type of MR scanner do you have the most experience with? Mark all that apply.

0.5T	
1.5 T	
3T	
None	

2. On average, how many MRI examinations of the body (excluding MSK exams) do you read per month?

3. Do you have experience with the following types of MRI examination? Mark all that apply in the middle column and state how many cases per month you are exposed to.

MRI type		**Number of cases per month**
Liver		
kidneys		
Pancreas		
Female GU		
Male GU		
Fetal		
MR angiography (MRA)		
MRI Cardiac		

4. How often do you protocol MRI examinations?

Additional comments:

US EXPERIENCE:

1-What type of US exams do you have experience with? Mark all that apply in the middle column and state how many cases per month you are exposed to.

US exam type		**Number of cases per month**
Abdominal US		
Renal/retroperitoneal		
Gynecological US		
First trimester OB		
Second trimester OB		
High risk OB		
Renal Transplant		

Liver Transplant		
Pancreas Transplant		

2. How often do you scan the patient yourself? (Highlight or circle)

Never	Only some cases	Only if the attending wants me to	Every case

Additional comments:

IMAGING GUIDED INTERVENTIONAL PROCEDURES:

1. What type of US guided invasive procedures do you have experience with? Mark all that apply in the middle column and provide the best approximation of the number of procedures you have performed.

Procedure type		**Number of cases**
Thoracentesis		
Paracentesis		
Other Aspiration		
Thyroid FNA		
Liver biopsy		
Superficial biopsy		

2-What type of CT guided invasive procedures do you have experience with? Mark all that apply. For each category, please provide the best approximation of the number of procedures you have performed.

Procedure Type		**Number of cases**
Lung biopsy		
Solid Organ biopsy		
Lymph node biopsy		
Peripheral mass biopsy		

Additional comments: