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

Desired academic year to begin training:	
First name	
Last name	
Business address and phone number:	
Home address and phone number:	
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, 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 and 2 letters from other faculty, colleagues, or fellowship directors

Name:	**Title:**	**Address:**

Signature:	**Date:**