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

Desired year to begin training:	
Full name:	
Email address:	

PREMEDICAL EDUCATION – for more room, include additional positions in your CV

College:	Location:	Date (from-to):	Degree:

MEDICAL EDUCATION – for more room, include additional positions in your CV

College:	Location:	Date (from-to):	Degree

INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS – for more room, include additional positions in your CV

Position:	Location:	Institution name:	Type of service:	Date (from-to):

USMLE Scores		
Step 1:	**Step 2:**	**Step 3:**

Board Eligibility & Licensing

1. Are you board eligible/certified?

☐ Yes

☐ No

2. ECFMG ID:	3. ECFMG Issue date:

4. Are you currently licensed to practice in another country?

☐ Yes

☐ No

Work Authorization

1. Are you currently authorized to work in the United States for the duration of the pathway?

☐ Yes

☐ No. See Question 2.

2. If no, will you require visa sponsorship?

☐ Yes

☐ No

Honors, Scholarships, and Grants

Membership in Professional Societies

Publications – for more room, attach additional publications on a separate page or include in your CV

Special Training and Interests – Please describe any special training or experience that could contribute to a research project during your training.

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 ☐Theranostics

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 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?		

Briefly narrate your reasons for seeking fellowship training, your long-range objectives and the amount and type of subsequent training you desire.

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. Please include institutional emails, such as ones ending in .edu or .org, etc. when possible.
Name, title, email, and specify the date range when you worked with this reference:
Name, title, email, and specify the date range when you worked with this reference:
Name, title, email, 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
- ☐ Other:

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 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
- ☐ 3 T
- ☐ 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 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	
☐ MRI MSK	

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 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?	
☐ 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 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:	

NUCLEAR MEDICINE EXPERIENCE:

For each question, please provide the best approximation of the number of studies/treatments you have performed.
1. Do you have experience with general nuclear medicine? If so, please specify the study types and numbers.

2. Do you have experience with PET/CT or PET/MRI? If so, please specify the radiopharmaceutical(s) and numbers.
3. Do you have experience with radiopharmaceutical therapy? If so, please specify the radiopharmaceutical(s) and numbers.