Boston Children's Hospital
Department of Radiology

HARVARD MEDICAL SCHOOL
Department of Radiology

Application for Pediatric Interventional Radiology Fellowship

Anticipated Start Date: _____

GENERAL INFORMATION

Name: _____
Last Name First Name Middle Name

Current Address: _____
Street City State/Country Zip Code

Email Address: _____

Telephone Numbers: _____
Home Work Mobile

Citizenship Status: ☐ US Citizen ☐ Permanent Resident ☐ J-1 visa ☐ H-1B Visa

EDUCATION

Undergraduate

College/University: _____

City and State/Country _____

Dates Attended: _____ Degree: _____ Major: _____

Medical School

College/University: _____

City and State/Country _____

Dates Attended: _____ Degree: _____ Major: _____

ECFMG Number: _____ Issue Date: _____

EXAMINATIONS

USMLE

Step 1: Date: _____ Status: _____
Step 2 CK: Date: _____ Status: _____
Step 2 CS: Date: _____ Status: _____
Step 3: Date: _____ Status: _____

Other Examinations:

Name of Exam: _____ Date: _____ Status: _____

Name of Exam: _____ Date: _____ Status: _____

PRIOR TRAINING

Internship

Institution: _____

City and State/Country: _____ Dates Attended: _____

Completed Program: ☐ Yes ☐ No Specialty/Area of Training: _____

Residency

Institution: _____

City and State/Country: _____ Dates Attended: _____

Completed Program: ☐ Yes ☐ No Specialty/Area of Training: _____

Fellowship

Institution: _____

City and State/Country: _____ Dates Attended: _____

Completed Program: ☐ Yes ☐ No Specialty/Area of Training: _____

REFERENCES

Names of three radiologists who will be writing letters of recommendation on your behalf. Please include at least one letter from an interventional radiologist. All letters should be addressed to Ahmad Alomari, MD, Program Director and should be mailed to Ahmad Alomari, MD, IR Fellowship Director, Boston Children's Hospital, 300 Longwood Avenue, Boston, MA 02115.

Reference #1		
Name:		
Address:		
City	State	Zip/Postal Code

Reference #2		
Name:		
Address:		
City	State	Zip/Postal Code

Reference #3		
Name:		
Address:		
City	State	Zip/Postal Code

E-Signature of Applicant	Date

Application Checklist:	
	Completed application
	Updated curriculum vitae (CV)
	Personal statement
	Photo – to be used for identification purposes only
	Request medical school transcript
	Request 3 letters of recommendation

SUBMIT COMPLETED APPLICATION TO:

AHMAD ALOMARI, MD
DIRECTOR, IR FELLOWSHIP PROGRAM
DEPARTMENT OF RADIOLOGY BOSTON
CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115
PHONE: (617) 355-6221
FAX: (617) 730-0573

SUBMIT FORM: ○