Boston Children's Hospital

Until every child is well℠

Pediatric Neuroradiology Fellowship

Your Contact Information

Fellowship Start Date

First Name

Middle Initial

Last Name

Degree(s)

Home Address

City

State

Zip code

Country

Professional Address

City

State

Zip code

Country

Home Phone

Work Phone

Social Security Number

Email Address

Date of Birth

Emergency Contact

Relationship

Telephone

Licensure to Practice Medicine

State/Province

License #

Your Education

Include name, location and degree date for first 3 items

High School

College

Medical School

Include hospital, location, type and dates for next 3 items

Internship

Residency

2nd Residence or Fellowship

Curriculum Vitae and Personal Statement

1. Please enclose a curriculum vitae in pdf or word doc format, including your publications, scientific exhibits and honors in medicine.
2. You must also request a copy of your medical school transcript.
3. For identification purposes only, please provide a small photograph.
4. Please include a one page personal statement.

References: Names of three diagnostic radiologists who will be writing letters of recommendation for you. These three letters should be addressed to:
Dr. Tina Young Poussaint, Program Director of Pediatric Neuroradiology, Boston Children's Hospital, Dept. of Radiology, 300 Longwood Avenue, Boston, MA 02115

First Name

Last Name

Hospital

Address

City

State

Zip code

First Name

Last Name

Hospital

Address

City

State

Zip code

First Name

Last Name

Hospital

Address

City

State

Zip Code

If you are not a citizen of the United States:

What type of visa will you hold while you are at Children's Hospital?

If you are in the U.S. on an Exchange Visitor Program, give name and program number of your current sponsor.

A graduate of a foreign medical school (except Canada) who will have any clinical responsibilities is required to pass the *United States Medical Licensing Exam (USMLE).* If you are certified, indicate below:

Standard Certificate Number (Copy must be sent)

Interim Certificate Number (Copy must be included)

Date of passing USMLE:

Have you taken and passed the Visa Qualifying Examination(VQE)?

- ◯ Yes
- ◯ No

Signature of Applicant

Date

Fellowship Application Checklist

- ☐ **Completed application**
- ☐ **Personal statement**
- ☐ **Medical school transcript**
- ☐ **Three letters of recommendation from radiologists**
- ☐ **Small photograph (used for identification purposes only)**

Please submit original application by regular mail to the following address:

Tina Young Poussaint, MD
Program Director, Pediatric Neuroradiology Fellowship
Department of Radiology
Boston Children's Hospital
300 Longwood Avenue
Boston, MA 02115
Email: tina.poussaint@childrens.harvard.edu
617-355-6450

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Submit