



Application for Pediatric 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: _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

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, including at least one letter in the specific area of anticipated fellowship. All letters should be addressed to Dr. Micheal Breen, Program Director and should be sent to Jane Choura, Fellowship Program Coordinator, 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
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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:

JANE CHOURA
 COORDINATOR, FELLOWSHIP PROGRAM
 DEPARTMENT OF RADIOLOGY
 CHILDREN'S HOSPITAL
 300 LONGWOOD AVENUE
 BOSTON, MA 02115
 PHONE: (617) 355-6290
 FAX: (617) 730-0573

SUBMIT FORM: