



**Boston  
Children's  
Hospital**

Until every child is well™

## Pediatric Neuroradiology Fellowship

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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

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Emergency Contact

Relationship

Telephone

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Licensure to Practice Medicine

State/Province

License #

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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**

### **Which Fellowship will you complete prior to Pediatric Neuroradiology Fellowship?**

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### **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.

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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

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First Name

Last Name

Hospital

Address

City

State

Zip Code

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If you are not a citizen of the United States:

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

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

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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

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Signature of Applicant

Date

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**Fellowship Application  
Checklist**

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

**Please submit original application 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](mailto:tina.poussaint@childrens.harvard.edu)

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*Version Date: August 18, 2017*