# VCU Pediatric Radiology Fellowship Application

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| **Fellowship interest** | | **Year:** | |
| **Personal info** | | | |
| **Name:** | Last: | First: | Middle Initial: |
| **Date of Birth:** | | **Place of Birth:** | |
| **Address:** | | | |
| **City, State & Zip:** | | | |
| **Phone:** | ☐ Home ☐ Cell ☐ Work | | |
| **Email:** | | | |
| **NPI #:** | | | |
| **Citizenship:** | | | |
| **VISA Type (J1, H1, F1, etc):** (please supply proof of visa status) | **Expiration Date:** | **Permanent Resident:** ☐ Yes ☐ No | **Other:** |
| **Education** | | | |
| **Premedical College:** | | Degree: | Year Completed: |
| **Medical School:** | | Degree: | Year Completed: |
| **If foreign trained, do you have an ECFMG Certificate:** ☐ Yes ☐ No | **Certificate No:** | | **Date:** |
| **AMERICAN RADIOLOGY EXAM:** ☐ American Board of Radiology ☐ American Osteopathic Board of Radiology | | | |
| CORE EXAM: Eligible? ☐ Yes ☐ No Already Taken? ☐ Yes ☐ No | If NOT taken, Expected exam dates: | If ALREADY taken, Exam dates/result: | |
| **STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE:** | | | |
| State: | License #: | Expiration Date: | |
| State: | License #: | Expiration Date: | |
| Have you ever been denied or lost a state license? ☐ Yes ☐ No If yes, explain why: | | | |
| **Training** | | | |
| **Internship (Post-Graduate Year 1)** | | | |
| Hospital (Institution & Location): | Type of Training: | Dates: | |
| **Radiology Residency** | | | |
| Hospital (Institution & Location): | | Dates: | |
| **Other education/training/research: Please list in chronological order.** | | | |
| Type of Training: | Institution: | Location (City, State): | Dates: |
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| **Honors Received:** | | | |
| **Society Memberships:** | | | |
| **Post-training experience (if applicable)** | | | |
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| **Do any of the exceptions to the SCARD embargo guidelines listed below apply to you?** | | | |

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| ☐ Applicants whose spouse/domestic partner is also applying for a medical fellowship in the same year.<br>☐ Internal candidates<br>☐ Military candidates<br>☐ International candidates – (Not from an ACGME or RCPS program) |
| **References; Please list letter writers (3) name, institution, and email address** |
| 1 (Current Program Director or Chairperson): |
| 2 (Selected Subspecialty Radiologist with whom you have worked): |
| 3 (MD/DO Letter writer of your choice): |

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| Date: | Signature: |