**Application for University of Washington Four Year Pathway**

**WE ACCEPT TYPED APPLICATIONS ONLY. HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.**

INSTRUCTIONS

The completed form should be returned to Trixie Rombouts ([btrxe@uw.edu](mailto:btrxe@uw.edu))

Date Date you wish to begin training

Full name

Date of birth

Citizenship

Business address Phone

Home address Phone

PREMEDICAL EDUCATION

College Address Date: From-To Degree

MEDICAL EDUCATION

College Address Date: From-To Degree

INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS

Position City Institution Type of service Date From-To

USMLE Step 1: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Step 2 CK: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Step 2 CS: Pass / Fail Step 3: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_

ARE YOU LICENSED TO PRACTICE MEDICINE? Where?

MILITARY SERVICE AND PRESENT STATUS

Board Eligibility

• ECFMG status or other qualifications

• Visa type Visa number Visa expiration

HONORS, SCHOLARSHIPS, GRANTS

Membership in Professional Societies

Publications

SPECIAL TRAINING AND INTERESTS

• Have you had any special training or experience that could contribute to a research project during your training? If so, please describe

YES answers to the following questions require a written explanation on a separate sheet (positive responses to questions do not necessarily preclude acceptance).

Have you ever been involved in a malpractice lawsuit or claim (whether or not you were Yes No

individually named as a defendant)?

Have you ever been called before any entity for questioning concerning unprofessional conduct, Yes No

incompetence, negligence, unsafe practices, or mental or physical impairment?

If you have been licensed to practice medicine, has any such license, or application for it, ever Yes No

been denied, revoked, suspended, or restricted?

Have you ever been addicted to, or treated for addiction to, a controlled substance, drug, or chemical? Yes No

Have you ever used a prescription drug, including controlled substances, for other than therapeutic Yes No

purposes?

Are you currently suffering from any disability or illness (mental or physical) that could affect your Yes No

ability to fully practice medicine?

On a separate sheet narrate your reasons for seeking fellowship training, your long range objectives in radiology and the amount and type of subsequent training you desire.

• Where do you contemplate locating after your training?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERENCES

• List a minimum of three references. **We require three letters of recommendation including a letter from your residency training program, a letter from your current fellowship (if attending), and a letter from other faculty, colleagues, or fellowship directors.**

Name Title Address

Signature Date

**CLINICAL EXPERIENCE QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CT EXPERIENCE:**

1-What type of CT scanner do you have most experience with? Mark all that apply.

|  |  |
| --- | --- |
| 64 slice MDCT |  |
| 256 slice or newer generation MDCT |  |
| Dual energy |  |
| Dual source |  |
| Revolution (GE) or similar |  |
| Others |  |
| None |  |

2-On the average, how many CT exams do you read per day?

3-Do you have experience with the following types of CT examination? Mark all that apply. For each category please state how many cases per month you are exposed to.

|  |  |  |
| --- | --- | --- |
| CT Type |  | Number of cases per month |
| CT angiography (CTA of chest or abd or pel including PE studies) |  |  |
| Multiphase CT of liver |  |  |
| Multiphase CT of pancreas |  |  |
| Routine CT Abd/Pel |  |  |
| CT IVP |  |  |
| CT chest |  |  |
| CTA coronary or cardiac |  |  |

4-How often do you protocol CT examinations in your practice?

Comments:

**CLINICAL EXPERIENCE QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MRI EXPERIENCE:**

1-What type of MR scanner do you have most experience with? Mark all that apply.

|  |  |
| --- | --- |
| 0.5T |  |
| 1.5 T |  |
| 3T |  |
| None |  |

2-On the average, how many MRI examination of the body (excluding MSK exams) do you read per month?

3-Do you have experience with the following types of MRI examination? Mark all that apply. For each category state how many cases per month you are exposed to.

|  |  |  |
| --- | --- | --- |
| MRI type |  | Number of cases per month |
| Liver |  |  |
| kidneys |  |  |
| Pancreas |  |  |
| Female GU |  |  |
| Male GU |  |  |
| Fetal |  |  |
| MR angiography (MRA) |  |  |
| MRI Cardiac |  |  |

4-How often do you protocol MRI examinations?

Comments:

**CLINICAL EXPERIENCE QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**US EXPERIENCE:**

1-What type of US exams do you have experience with? Mark all that apply. For each category please state the average number of cases you are exposed to per month.

|  |  |  |
| --- | --- | --- |
| US exam type |  | Number of cases per month |
| Abdominal US |  |  |
| Renal/retroperitoneal |  |  |
| Gynecological US |  |  |
| First trimester OB |  |  |
| Second trimester OB |  |  |
| High risk OB |  |  |
| Renal Transplant |  |  |
| Liver Transplant |  |  |
| Pancreas Transplant |  |  |

2-How often do you scan the patient yourself?

|  |  |
| --- | --- |
| Never |  |
| Only some cases |  |
| Only if the attending wants me to |  |
| Every case |  |

Comments:

**CLINICAL EXPERIENCE QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMAGING GUIDED INTERVENTIONAL PROCEDURES:**

1-What type of US guided invasive procedures do you have experience with? Mark all that apply. For each category please provide the best approximation of the number of procedures you have performed.

|  |  |  |
| --- | --- | --- |
|  |  | Number of cases |
| Thoracentesis |  |  |
| Paracentesis |  |  |
| Other Aspiration |  |  |
| Thyroid FNA |  |  |
| Liver biopsy |  |  |
| Superficial biopsy |  |  |

2-What type of CT guided invasive procedures do you have experience with? Mark all that apply. For each category please provide the best approximation of the number of procedures you have performed.

|  |  |  |
| --- | --- | --- |
|  |  | Number of cases |
| Lung biopsy |  |  |
| Solid Organ biopsy |  |  |
| Lymph node biopsy |  |  |
| Peripheral mass biopsy |  |  |

Comments: