**APPLICATION FOR CARDIOTHORACIC FELLOWSHIP TRAINING**

**University of Washington Department of Radiology**

**SEATTLE, WASHINGTON**

INSTRUCTIONS

The completed form should be returned to Trixie Rombouts, Program Administrator, btrxe@uw.edu. NO handwritten applications will be accepted.

Date Date you wish to begin training

Full name (last, first, middle)

Date of birth

Citizenship

Business address Phone

Home address Phone

Preferred email address:

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

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 additional references.

Name Title Address

Signature Date