

# Application for the University of Washington 4-Year ABR Alternate Pathway

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

The completed form should be returned to Kathy Nguyen at [kn38@uw.edu](mailto:kn38@uw.edu)

|  |                  |                          |                         |                        |
|--|------------------|--------------------------|-------------------------|------------------------|
| <b>Date you wish to begin training:</b>          |                  |                          |                         |                        |
| <b>Full name:</b>                                |                  |                          |                         |                        |
| <b>Date of birth:</b>                            |                  |                          |                         |                        |
| <b>Citizenship:</b>                              |                  |                          |                         |                        |
| <b>Business address:</b>                         |                  |                          | <b>Phone:</b>           |                        |
| <b>Home address:</b>                             |                  |                          | <b>Phone:</b>           |                        |
| <b>Email address:</b>                            |                  |                          |                         |                        |
| <b>PREMEDICAL EDUCATION</b>                      |                  |                          |                         |                        |
| <b>College:</b>                                  | <b>Address:</b>  | <b>Date (from-to):</b>   | <b>Degree:</b>          |                        |
|  |                  |                          |                         |                        |
|  |                  |                          |                         |                        |
| <b>MEDICAL EDUCATION</b>                         |                  |                          |                         |                        |
| <b>College:</b>                                  | <b>Address:</b>  | <b>Date (from-to):</b>   | <b>Degree</b>           |                        |
|  |                  |                          |                         |                        |
|  |                  |                          |                         |                        |
| <b>INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS</b> |                  |                          |                         |                        |
| <b>Position:</b>                                 | <b>Location:</b> | <b>Institution name:</b> | <b>Type of service:</b> | <b>Date (from-to):</b> |
|  |                  |                          |                         |                        |
|  |                  |                          |                         |                        |
|  |                  |                          |                         |                        |

|  |  |  |  |  |
|--|--|--|--|--|
|  |  |  |  |  |
|  |  |  |  |  |

**USMLE Scores**

|   |                |                |
|---|----------------|----------------|
| <b>Step 1</b> (highlight or circle one):<br><br>PASS / FAIL | <b>Step 2:</b> | <b>Step 3:</b> |
|---|----------------|----------------|

Are you licensed to practice medicine? If so, where?

Military service and present status:

**Board Eligibility**

ECFMG status or other qualifications:

|                   |                     |                         |
|-------------------|---------------------|-------------------------|
| <b>Visa type:</b> | <b>Visa number:</b> | <b>Visa expiration:</b> |
|-------------------|---------------------|-------------------------|

**Honors, Scholarships, and 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 any of 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 individually named as a defendant)?   | Yes | No |
| Have you ever been called before any entity for questioning concerning unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment? | Yes | No |
| If you have been licensed to practice medicine, has any such license, or application for it, ever been denied, revoked, suspended or restricted?                             | Yes | No |
| 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 purposes?  | Yes | No |
| Are you currently suffering from any disability or illness (mental or physical) that could affect your ability to fully practice medicine?                                   | Yes | No |

**Please narrate your reasons for seeking fellowship training, your long-range objectives and the amount and type of subsequent training you desire. Where do you contemplate locating after your training?**

**References. We require 3 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**

|                   |               |                 |
|-------------------|---------------|-----------------|
| <b>Name:</b>      | <b>Title:</b> | <b>Address:</b> |
|                   |               |                 |
|                   |               |                 |
|                   |               |                 |
| <b>Signature:</b> |               | <b>Date:</b>    |
|                   |               |                 |

## CLINICAL EXPERIENCE QUESTIONNAIRE

### CT EXPERIENCE:

1. What type of CT scanner do you have the 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 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 in the middle column and state how many cases per month you are exposed to.

| <b>CT Type</b>   |  | <b>Number of cases per month</b> |
|--|--|----------------------------------|
| 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?

Additional comments:

**MRI EXPERIENCE:**

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

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

2. On average, how many MRI examinations 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 in the middle column and state how many cases per month you are exposed to.

| <b>MRI type</b> |  | <b>Number of cases per month</b> |
|-----------------|--|----------------------------------|
| Liver           |  |                                  |
| kidneys         |  |                                  |
| Pancreas        |  |                                  |
| Female GU       |  |                                  |
| Male GU         |  |                                  |
| Fetal           |  |                                  |

|                      |  |  |
|----------------------|--|--|
| MR angiography (MRA) |  |  |
| MRI Cardiac          |  |  |

4. How often do you protocol MRI examinations?

Additional comments:

**US EXPERIENCE:**

1-What type of US exams do you have experience with? Mark all that apply in the middle column and state how many cases per month you are exposed to.

| 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? (Highlight or circle)

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

Additional comments:

**IMAGING GUIDED INTERVENTIONAL PROCEDURES:**

1. What type of US guided invasive procedures do you have experience with? Mark all that apply in the middle column and provide the best approximation of the number of procedures you have performed.

| <b>Procedure type</b> |  | <b>Number of cases</b> |
|-----------------------|--|------------------------|
| 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.

| <b>Procedure Type</b>  |  | <b>Number of cases</b> |
|------------------------|--|------------------------|
| Lung biopsy            |  |                        |
| Solid Organ biopsy     |  |                        |
| Lymph node biopsy      |  |                        |
| Peripheral mass biopsy |  |                        |

Additional comments: