Application for Fellowship: University of MS Medical Center

Subspecialty Program:	Neuroradiology	Starting Date

Name:	Last	First	Middle Init

Date of Birth:	
Address 1:	
Address 2:	
Address 3:	
Telephone (Cell):	
Telephone (Work):	
Email:	
Pager #	
Citizenship	

VISA Type (J1, H1, F1, etc.) (proof of visa status must accompany application)	Expiration Date:	Permanent Resident? ☐ YES ☐ NO	Other:

Education:

Premedical College:	Degree:	Year Completed:
Medical School:	Degree:	Year Completed:

If foreign trained, have you taken:	ECFMG EXAM:	where:	Date:	Certificate No.
USMLE or LMCC EXAM: (copies of ECFMG and USMLE must be included)		where:	Date:	Results:

AMERICAN BOARD of RADIOLOGY EXAMS:

Core Exam (check box) ☐Pass ☐ Fail	Date Taken (mm/yy)	Certifying Exam (check box) ☐Pass ☐ Fail ☐N/A

STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE:

State:	License #:	Expiration Date:

Have you ever been denied or lost a state license? If yes explain why: (if you need additional space, please attach document)

Training:

1st Post Graduate Year (Internship):

Hospital:	Type of Training:	Dates:

Other education, training or hospital research : (please list in chronological order, including your present position)

Name:	Address:	Type of Training:	Dates:
Name:	Address:	Type of Training:	Dates:
Name:	Address:	Type of Training:	Dates:
Name:	Address:	Type of Training:	Dates:

REFERENCES: List names, institutions, and phone number/email address of three physicians who are writing letters for you:

1:

2:

3:

Date (Signed) _____

Click on each box to enter your information. You can then save and print or email your completed form.
Please visit **www.umc.edu/neuroradiology** for list of additional documents needed for consideration of fellowship.