

Application for Fellowship

Subspecialty Program _____

Starting Date _____

NAME _____
last first middle

DATE OF BIRTH _____

ADDRESS _____

TELEPHONE (HOME) _____
TELEPHONE (WORK) _____

EMAIL _____

PAGER# _____

CITIZENSHIP _____

VISA Type (J1, H1, F1, etc.) _____ Expiration date: _____ Permanent Resident? _____ Other _____
(proof of visa status must accompany application)

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 _____ where _____ date _____ results _____
(copies of ECFMG and USLME to be included)

AMERICAN BOARD of RADIOLOGY EXAMS

Physics _____ Written _____ Oral _____
(dates taken and results)

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.

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)

Institution _____
name address type of training dates

REFERENCES: please list the names and institutions of three physicians who will be writing letters for you.
**One of the three letters of recommendation must be from your program director

Dale _____ (Signed) _____

Please send this cover sheet with copies of your CV, Dean's letter, USMLE transcript, proof of graduation from medical school, and personal statement
TO: Leon Rybak, M.D. Program Director, Hospital for Joint Diseases – Radiology Department – Suite 600, 301 East 17th Street, NYC, NY 10003