MICHIGAN STATE UNIVERSITY | Department of Radiology

# Application for Fellowship

## Women's Imaging/Musculoskeletal Radiology Fellowship

Starting Date _____

Name _____. _____ _____
last first middle

Date of Birth _____ Address _____

Telephone: Home _____ 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 _____

### EXAMS

American Board of Radiology or American Osteopathic Board of Radiology Exams:

Physics _____ Written _____ Oral _____

*(dates taken and results)*

If foreign trained, have you taken:

ECFMG Exam ____ Where _____ Date _____ Certificate No. _____

USMLE or LMCC Exam ____ Where _____ Date _____ Certificate No. _____

*(copies of ECFMG and USMLE must be included)*

### LICENSING *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)*

_____ _____ _____ _____
instituion name address type of training dates

### REFERENCES *Please list the names and institutions of three physicians who will be writing letters for you.*

_____ _____ _____

Signature X _____ Date _____

**Interested candidates should include a letter of introduction, curriculum vitae, and 3 letters of reference.**



END OF FORM