BRIGHAM AND
WOMEN'S HOSPITAL

HARVARD
MEDICAL SCHOOL

Abdominal Imaging and Intervention (AII) Fellowship Application Form

FELLOWSHIP STARTING DATE:

NAME OF APPLICANT (last, first, middle):

DATE OF BIRTH:

ADDRESS:

TELEPHONE (HOME): **TELEPHONE (WORK):**

EMAIL: **PAGER #:**

CITIZENSHIP: **PERMANENT RESIDENT:** **VISA** (Type / expiration date):

EDUCATION:

Premedical College (Institution, degree, year completed):

Medical School (Institution, degree, year completed):

TRAINING (please list in chronological order, including your present position):

1st Post Graduate Year (Internship) (hospital name / address, type and dates of training):

Residency (hospital name / address, type and dates of training):

OTHER TRAINING / POSITION (clinical or research):

USMLE or LMCC EXAMS (Dates taken / Result / Score) (copies of ECFMG and USMLE exams must be included):

USMLE 1: USMLE 2CK: USMLE 2CS: USMLE 3:

LMCC:

AMERICAN BOARD of RADIOLOGY EXAMS (dates taken and results):

Physics_____ Written_____ _____ Oral_____ _____

STATES (in which you are licensed to practice medicine):

State _____ License # _____ Expiration Date _____

State _____ License # _____ Expiration Date _____

Have you ever been denied or lost a state license? If yes explain why (you may use a separate paper).

REFERENCES (please list the names and institutions of three physicians who will be writing letters for you):

1)

2)

3)

Date: _____ **Signature**: _____

Please send this cover sheet with a copy of your CV, recent photograph, personal statement, three recommendation letters addressed to the fellowship director, copies of USMLE exam results, and ECFMG certificate if you are a foreign medical graduate.