VCU Common Application for Radiology Fellowship

Fellowship interest			**Year:**	
Fellowship:	☐ Abdominal ☐ MSK ☐ Breast ☐ Women's Imaging ☐ CardioThoracic ☐ ThoracoAbdominal ☐ MRI* ☐ Hybrid**			
*** If MRI select up to 4 rotations:**	☐ Abdominal ☐ MSK ☐ Neuro ☐ Thoracic ☐ Cardiac			
**** If Hybrid select up to 4 rotations:**	☐ Abdominal ☐ MSK ☐ Neuro ☐ Thoracic ☐ Cardiac ☐ Breast			
Personal info				
Name:	Last:	First:	Middle Initial:	
Date of Birth:		**Place of Birth:**		
Address:				
City, State & Zip:				
Phone:	☐ Home ☐ Cell ☐ Work			
Email:				
NPI #:				
Citizenship:				
VISA Type (J1, H1, F1, etc): (please supply proof of visa status)	**Expiration Date:**	**Permanent Resident:** ☐ Yes ☐ No	**Other:**	
Education				
Premedical College:		Degree:	Year Completed:	
Medical School:		Degree:	Year Completed:	
If foreign trained, do you have an ECFMG Certificate: ☐ Yes ☐ No	**Certificate No:**	**Date:**		
AMERICAN RADIOLOGY EXAM: ☐ American Board of Radiology ☐ American Osteopathic Board of Radiology				
CORE EXAM: Eligible? ☐ Yes ☐ No Already Taken? ☐ Yes ☐ No	If NOT taken, Expected exam dates:	If ALREADY taken, Exam dates/result:		
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? ☐ Yes ☐ No If yes, explain why:				
Training				
Internship (Post-Graduate Year 1)				
Hospital (Institution & Location):	Type of Training:	Dates:		
Radiology Residency				
Hospital (Institution & Location):		Dates:		
Other education/training/research: Please list in chronological order.				
Type of Training:	Institution:	Location (City, State):	Dates:	
Type of Training:	Institution:	Location (City, State):	Dates:	
Type of Training:	Institution:	Location (City, State):	Dates:	
Honors Received:				
Society Memberships:				
Post-training experience (if applicable)				

Do any of the exceptions to the SCARD embargo guidelines listed below apply to you?	
☐ Applicants whose spouse/domestic partner is also applying for a medical fellowship in the same year. ☐ Internal candidates ☐ Military candidates ☐ International candidates – (Not from an ACGME or RCPS program)	
References; Please list letter writers (3) name, institution, and email address	
1 (Current Program Director or Chairperson):	
2 (Selected Subspecialty Radiologist with whom you have worked):	
3 (MD/DO Letter writer of your choice):	
Date:	Signature: