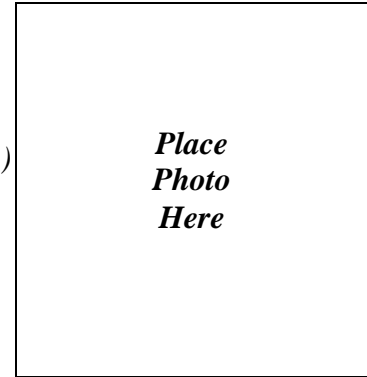


# MUSCULOSKELETAL FELLOWSHIP APPLICATION

Department of Radiology  
The Ohio State University Medical Center



1. Application Requirements
2. Completed application form (If not applicable, please put n/a)
3. Transcript of medical school grades (copy will suffice)
4. Three recent letters of recommendation
5. 2X2 passport photograph (staple to corner of application)
6. Curriculum vitae
7. Personal Statement

**Directions--Please print or type answers**

## Identification Information

Name \_\_\_\_\_

I can BEST be reached at Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Permanent Address \_\_\_\_\_  
Street City, State, Zip Country (if not USA)

Mailing Address \_\_\_\_\_  
Street City, State, Zip Country (if not USA)

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

**If a foreign medical graduate please provide the following information**

**Are you a citizen of the United States?**

- Yes
- No

**If you answered No to the above, please provide your Immigration status**

- Permanent
- J-1 Exchange visitor
- H-L temporary student/trainee
- Other \_\_\_\_\_

**Are you certified in Radiology in your home country?**

- Yes
- No

ECFMG Certificate Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

- Interim
- Permanent

**Fellowship Information**

Application Year *July* \_\_\_\_\_ to *June* \_\_\_\_\_

**Areas of special interest, if any**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Education Information**

**Undergraduate Education**

Name of Institution \_\_\_\_\_ Graduation Date \_\_\_\_\_

Address \_\_\_\_\_ Degree \_\_\_\_\_

**Medical Education**

Name of Institution \_\_\_\_\_ Graduation Date \_\_\_\_\_

Address \_\_\_\_\_ Degree \_\_\_\_\_

**National Board Scores**

USMLE    Part I \_\_\_\_\_ Part II \_\_\_\_\_ Part III \_\_\_\_\_  
 COMLEX    Part I \_\_\_\_\_ Part II \_\_\_\_\_ Part III \_\_\_\_\_

**Internship Training**

Name of Institution \_\_\_\_\_ Dates of Service \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_

**Residency Training**

Name of Institution \_\_\_\_\_ Dates of Service \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_

<b>Radiology Board Examinations</b>	<b>Dates Taken</b>	<b>Results</b>
Core	_____	_____
Certification	_____	_____
Other _____	_____	_____

**Other postgraduate training** \_\_\_\_\_

\_\_\_\_\_

**Membership in organization, professional, and other** \_\_\_\_\_

\_\_\_\_\_

**Are you eligible for VA benefits?**

- Yes    Branch of Service \_\_\_\_\_
- No

**Experience (practical or hospital)** \_\_\_\_\_

\_\_\_\_\_

**References**--From persons acquainted with your educational and professional work within the last 3 years. Please include the Program Director of your residency, current, or last educational program (name, address, and position).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Have you ever been suspended, expelled, or resigned from any medical school or hospital appointment? If yes, explain** \_\_\_\_\_

\_\_\_\_\_

**Have you ever been convicted of a misdemeanor?**

- Yes
- No

**If yes, explain** \_\_\_\_\_

\_\_\_\_\_

**Have you ever been convicted of a felony?**

- Yes
- No

**If yes, explain** \_\_\_\_\_

\_\_\_\_\_

**Is there anything in your past history that would limit your availability to be licensed or would limit your ability to receive hospital privileges?**

- Yes
- No

**If yes, explain** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you licensed to practice medicine in Ohio?**

- Yes    Expiration date \_\_\_\_\_
- No

**Extracurricular medical experience not covered by the above questions**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Scientific papers which have been published**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPLICANT’S NOTICE**-- Appointments can be made for one year only, subject to continuing advancement as opportunity and appearance permit, but this information is not obligated to extend any appointment beyond one year. Appointments are made for a specific service. No departmental chairperson can guarantee an appointment on service outside of his/her own department, but such interchange may be accomplished if and when it is mutually advantageous to all concerned.

The application is made with the understanding that if I am appointed I will serve for the full time for which I am appointed, and I will faithfully observe the rules and regulations of The Ohio State University.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*Please send all required documentation to:*

**Jason E. Payne, M.D.**  
*Musculoskeletal Fellowship Program Director*  
**c/o Samantha Schnitzer, Program Manager**  
**The Ohio State University Medical Center**  
**Department of Radiology**  
**395 West 12<sup>th</sup> Avenue**  
**4<sup>th</sup> Floor**  
**Columbus, OH 43210-1250**  
**614-293-8369 phone**  
**614-293-6935 fax**  
**Samantha.Schnitzer@osumc.edu e-mail**