MUSCULOSKELETAL FELLOWSHIP APPLICATION

Department of Radiology
The Ohio State University Medical Center

Place Photo Here

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?
- o Yes
- o No

If you answered No to the above, please provide your Immigration status
- o Permanent
- o J-1 Exchange visitor
- o H-L temporary student/trainee
- o Other_____

Are you certified in Radiology in your home country?
- o Yes
- o No

ECFMG Certificate Number _____ Expiration Date _____
- o Interim
- o Permanent

Fellowship Information

Application Year *July* _____ to *June* _____

Areas of special interest, if any

1. _____ 3. _____

2. _____ 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 _____

Radiology Board Examinations	Dates Taken	Results
Core	_____	_____
Certification	_____	_____
Other_____	_____	_____

Other postgraduate training_____
_____
_____

Membership in organization, professional, and other_____
_____
_____

Are you eligible for VA benefits?

- o Yes Branch of Service _____
- o 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?

- o Yes
- o No

If yes, explain_____
_____
_____

Have you ever been convicted of a felony?

- o Yes
- o 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?

- o Yes
- o No

If yes, explain_____
_____
_____

Are you licensed to practice medicine in Ohio?

- o Yes Expiration date_____
- o 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
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4th Floor
Columbus, OH 43210-1250
614-293-8369 *phone*
614-293-6935 *fax*
Samantha.Schnitzer@osumc.edu *e-mail*