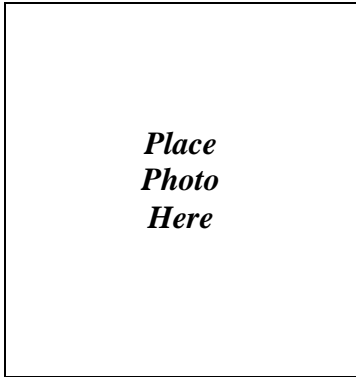


NEURORADIOLOGY FELLOWSHIP APPLICATION

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)

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 InformationApplication 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?

- 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:

Wayne Slone, M.D.
Neuroradiology Fellowship Program Director
c/o Samantha Schnitzer, Program Manager
The Ohio State University Medical Center
Department of Radiology
395 W 12th Ave
4th Floor
Columbus, OH 43210
614-293-8369 phone
614-293-6935 fax
Samantha.Schnitzer@osumc.edu e-mail