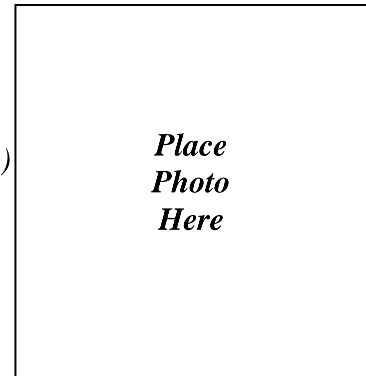
THORACIC IMAGING FELLOWSHIP APPLICATION

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*
8. *USMLE Scores 1-3 Documentation*

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?
- 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?

- 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:

Mark King, M.D.
Thoracic Imaging Fellowship Program Director
c/o Samantha Schnitzer, *Program Manager*
The Ohio State University Medical Center
Department of Radiology
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4th Floor
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614-293-8369 *phone*
614-293-6935 *fax*
Samantha.Schnitzer@osumc.edu *e-mail*