UCDAVIS HEALTH | SCHOOL OF MEDICINE

Department of Radiology Fellowship Application

Subspecialty Program:		Starting Date:

Name:	Last	First	Middle Initial

Date of Birth:	
Address 1:	
Address 2:	
Address 3:	
Telephone (Home):	
Telephone (Work):	
Email:	
Pager #	
Citizenship	

VISA Type (J1, H1, F1, etc.) (Proof of visa status must accompany application)	Expiration Date:	Permanent Resident? ☐Yes ☐No	Other:

Education:

Premedical College:	Degree	Year Completed:
Medical School:	Degree:	Year Completed:

If foreign trained, have you taken:	ECFMG EXAM:	where:	Date:	Certificate No.
USMLE or LMCC EXAM: (copies of ECFMG and USMLE must be included)		Where:	Date:	Results:

AMERICAN BOARD of RADIOLOGY EXAMS:

(Dates Taken & Results)	Written:	Oral:

STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE:

State:	License #:	Expiration Date:

Have you ever been denied or lost a state license? If yes, explain why:

Training:

1st Post Graduate Year (Internship):

Hospital:	Type of Training:	Dates:

Other Education, Training or Hospital Research: (Please list in chronological order, including your present position)

Name:	Address:	Type of Training:	Dates:
Name:	Address:	Type of Training:	Dates:
Name:	Address:	Type of Training:	Dates:
Name:	Address:	Type of Training:	Dates:

REFERENCES: Please list the names and institutions of three physicians who will be writing letters for you:

1.	4.
2.	5.
3.	6.

Date: (Signed) _____

Please send this cover sheet with a copy of your CV and a personal statement to the fellowship director at the address specified by the program. One of the letters of recommendation must be from your program director. Please note some programs, in addition, we require copies of your Dean's letter, USMLE transcript and/or proof of graduation from medical school. Click on each box to enter your information. You can then Save and Print your completed form.