Department of Radiology
FELLOWSHIP APPLICATION CHECKLIST

Name of Applicant: ________________________________________

Fellowship start date: ______________________________________

☐ Completed application
Please be sure to sign your application

☐ Curriculum Vitae with cover letter
Should include education, work experience, publications, scientific exhibits and honors in medicine

☐ Three letters of recommendation
Letters of recommendation, addressed to the Program Director, must be written by Radiologists, at least one of whom is a PEDIATRIC Radiologist. Letters of recommendation MUST be requested by the applicant AND sent under separate cover DIRECTLY to the Program Director:

Scott A. Jorgensen, M.D.
Pediatric Radiology Fellowship Program Director
Phoenix Children’s Hospital
1919 E. Thomas Road
Phoenix, AZ 85016

☐ Small photograph
For identification purposes. Please affix to page 2 where stated.

RETURN COMPLETED APPLICATION AND DIRECT ALL CORRESPONDENCE TO:

Mirna Valenzuela
Sr. Medical Education Program Administrator
Phoenix Children’s Hospital
1919 E. Thomas Road
Phoenix, AZ 85016
Telephone: 602-933-2089
Fax: 602-933-1264
E-mail: mvalenzuela@phoenixchildrens.com
Department of Radiology
FELLOWSHIP APPLICATION

(Please check applicable fellowship program)

□ Pediatric Radiology  □ Pediatric Interventional Radiology  □ Pediatric Neuroradiology

PERSONAL INFORMATION

Last  First  Middle

Current Address

Current Address

Home Telephone  Work Telephone  Cellular Telephone

E-mail address  Date of Birth

Social Security Number  NPI Number (National Provider ID, if applicable)

Emergency Contact  Relationship  Telephone

Place of Birth  Country of Citizenship

USMLE:  Step 1:  Date:  ________________  Score:  ________________
        Step 2 CK: Date:  ________________  Score:  ________________
        Step 2 CS: Date:  ________________  Score:  ________________
        Step 3:  Date:  ________________  Score:  ________________

□ Board Eligible in Diagnostic Radiology  Anticipated date of Boards?  ________________

□ Board Certified in Diagnostic Radiology  Date of Certification?  ________________
If not a U.S. Citizen:

What type of visa will you hold while you are at Phoenix Children’s Hospital? ____________

If you are in the U.S. on an Exchange Visitor Program, give the name and program number of your current sponsor: ____________________________________________

A graduate of foreign school (except Canada) who will have any clinical responsibilities is required to pass the United States Medical Licensing Exam (USMLE).

If you are certified, indicate below:

Standard Certificate: Number: ______________________ (copy must be included)

Interim Certificate: Number: ______________________ (copy must be included)

E.C.F.M.G. (if foreign trained) Number: _______________________________________

LICENSED to practice medicine in the State/Province of:

_________________________________ ___________________ ______________
State/Province License Number

_________________________________ ___________________ ______________
State/Province License Number

_________________________________ ___________________ ______________
State/Province License Number

EDUCATION:

College/University:

Institution: ___________________________ Location: ___________________________

Degree: ___________________________ Dates attended: ___________________________

Institution: ___________________________ Location: ___________________________

Degree: ___________________________ Dates attended: ___________________________
Medical School:

__________________________
Institution Location

______________________________
Degree Dates attended

Internship:

__________________________
Institution Location Dates attended

__________________________
Institution Location Dates attended

Residency:

__________________________
Institution Location Dates attended

__________________________
Institution Location Dates attended

Fellowship:

__________________________
Institution Location Dates attended

__________________________
Institution Location Dates attended

Other post-graduate work: _______________________________________________________

_____________________________________________________________________________

LETTERS OF RECOMMENDATION:

1. Name Title
   __________________________________________________
   Address
   __________________________________________________
   E-mail address Telephone
GENERAL INFORMATION

- Have you ever elected to leave any program of education and/or training prior to completion?  □ YES □ NO

- Have you ever been asked or directed to leave any program of education and/or training prior to completion?  □ YES □ NO

- Are there any actions or proceedings which have involved the imposition of a sanction of suspension or dismissal from any program of education and/or training to date?  □ YES □ NO

- Have you ever pleaded guilty to or been convicted of a crime or offense other than a minor traffic violation?  □ YES □ NO

If YES to any of the above questions, please provide details on a separate page.

CERTIFICATION

I certify that the facts and information I have provided on this application, on other pre-employment documents and during interviews are true and complete; and I agree that if I receive an appointment, incorrect, incomplete or falsified information will be grounds for dismissal, regardless of when discovered.

_________________________  __________________
Signature                  Date