Children's National™

PEDIATRIC RADIOLOGY FELLOWSHIP TRAINING PROGRAM

APPLICATION CHECKLIST

☐ Completed Application

☐ Current CV

☐ Photo (in space provided)

☐ Personal Statement on career objectives and training expectations

☐ ECFMG certificate (if applicable)

☐ References: Three letters of reference are required (one from the residency program director if possible). Please list names and addresses of the attending physicians and/or faculty of whom you will request recommendations. These physicians should have definite knowledge of your qualifications and be acquainted with your work.

1. _____

2. _____

3. _____

This application and all related communications should be addressed to:

Narendra Shet, M.D.
Pediatric Radiology Fellowship Program Director
Children's National Medical Center
111 Michigan Avenue, N.W.
Washington, D.C. 20010-2970
Phone: 202-476-5630
Fax: 202-476-3644
E-mail: nshet@childrensnational.org

Application for Fellowship in Pediatric Radiology

Place photo here

From: _____ To: _____

Are you interested in a 2nd fellowship year? ☐ Yes ☐ No

If so, in what subspecialty area(s) ☐ Neuroradiology ☐ Nuclear Medicine ☐ Interventional Radiology ☐ Other: _____

1. PERSONAL DATA:

NAME: (LAST) (FIRST) (MIDDLE) _____	MAIDEN (if applicable) _____
PRESENT ADDRESS: (STREET) (CITY) (STATE) (ZIP) _____	
TELEPHONE: DAY: (___) _____	EVENING: (___) _____
PAGER #: (___) _____	EMAIL ADDRESS: _____

Citizenship Status: ☐ US Citizen ☐ Permanent Resident ☐ J1 Visa ☐ H1B Visa

Are you eligible or authorized to work in the US? ☐ Yes ☐ No

Valid Social Security No.: ☐ Yes ☐ No Birthplace: _____

Name, address, relationship and phone number of person to contact in case of emergency:

Name: _____ Relationship: _____

Address: _____

Phone #: _____

2. EDUCATION

UNDERGRADUATE (Include name, city, state, zip)	DATES ATTENDED FROM (MM/YY)	DATES ATTENDED TO MM/YY)	MAJOR	DEGREE
MEDICAL SCHOOL (Include name, city, state, zip)	**DATES ATTENDED FROM (MM/YY)**	**DATES ATTENDED TO MM/YY)**	**MAJOR**	**DEGREE**
ECFMG (if foreign trained): Number _____			Issue Date: _____	

3. PRIOR TRAINING

INTERNSHIP (Include name, city, state, zip)	DATES ATTENDED FROM (MM/YY)	DATES ATTENDED TO MM/YY)
Area of Training/Specialty: _____		
Completed Program: ☐ Yes ☐ No		

RESIDENCY: (Include name, city, state, zip)	DATES ATTENDED FROM (MM/YY)	DATES ATTENDED TO MM/YY)
Area of Training/Specialty: _____		
Completed Program: ☐ Yes ☐ No		

FELLOWSHIP: (Include name, city, state, zip)	DATES ATTENDED FROM (MM/YY)	DATES ATTENDED TO MM/YY)
Area of Training/Specialty: _____		
Completed Program: ☐ Yes ☐ No		

4. HONORS/AWARDS/ACCOMPLISHMENTS:

5. MEMBERSHIP IN ORGANIZATIONS (PROFESSIONAL & OTHERS):

Organization & Location	**Dates**

6. PUBLICATIONS/ RESEARCH EXPERIENCE:

7. EXAMINATIONS/CERTIFICATIONS:

USMLE		
Step 1	Date:	Score/Status:
Step 2 CK	Date:	Score/Status:
Step 2 CS	Date:	Score/Status:
Step 3	Date:	Score/Status:
OTHER EXAM:		
Exam	Date:	Score/Status:
Exam	Date:	Score/Status:

8. Do you have a state license to practice medicine? ☐ YES ☐ NO

If so, what State: _____ License #: _____

9. INTERVIEW SCHEDULING:

I am available to schedule an interview on the follow dates: (please specify)

Signature: _____ Date: _____