



PEDIATRIC RADIOLOGY FELLOWSHIP TRAINING PROGRAM

APPLICATION CHECKLIST

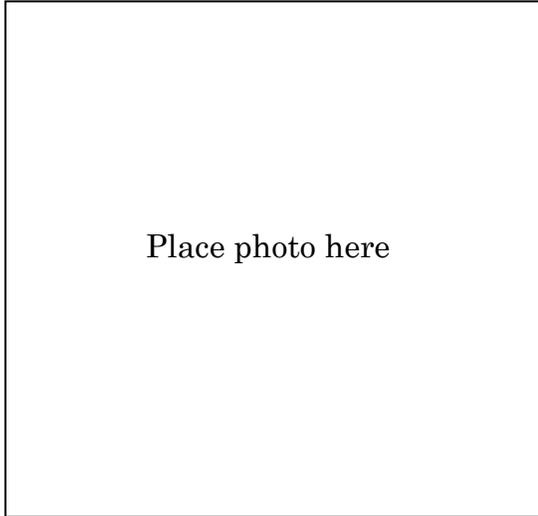
- Completed Application
- Current CV
- Photo (in space provided)
- Personal Statement on career objectives and training expectations
- ECFMG certificate (if applicable)
- References: Three letters of reference are required (one from the residency program director if possible). Please list names and addresses 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



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

3. PRIOR TRAINING

INTERNSHIP (Include name, city, state, zip)	DATES ATTENDED	
	FROM (MM/YY)	TO (MM/YY)
Area of Training/Specialty: _____		
Completed Program: <input type="checkbox"/> Yes <input type="checkbox"/> No		

RESIDENCY: (Include name, city, state, zip)	DATES ATTENDED	
	FROM (MM/YY)	TO (MM/YY)
Area of Training/Specialty: _____		
Completed Program: <input type="checkbox"/> Yes <input type="checkbox"/> No		

FELLOWSHIP: (Include name, city, state, zip)	DATES ATTENDED	
	FROM (MM/YY)	TO (MM/YY)
Area of Training/Specialty: _____		
Completed Program: <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____