Children's Healthcare of Atlanta

Pediatric Neuroradiology Fellowship Application

DEMOGRAPHICS:			Requested Start Date:
Last Name:	First:		Middle:
Date of Birth:			
Address 1:			
Address 2:			
Cell Phone:			
Email:			
Citizenship:			
If non-US Citizen, type of Visa held:			Exp Date:
ECFMG Certified? □ YES □ NO □ N/A	Date:		Certificate No:

EDUCATION:	Year Completed:
Premedical College:	
Medical School:	
Residency:	
Fellowship:	

ADDITIONAL TRAINING: List other education, training and research, including future fellowships.

Name:	Dates:
Name:	Dates:
Name:	Dates:
Name:	Dates:

MEDICAL LICENSURE:

State:	License No:	Expiration Date:
State:	License No:	Expiration Date:

US BOARD CERTIFICATION OR ELIGIBILITY:

Specialty:	□ Certified □ Eligible	Certificate Date:
Specialty:	□ Certified □ Eligible	Certificate Date:

REFERENCES: One of the letters of recommendation should be from your program director

Name:	Email:
Name:	Email:
Name:	Email:

I hereby certify that all the information on this application is accurate, complete, and current to the best of my knowledge.

Signature:	Date:

- Please send this application with a copy of your CV and a personal statement to the fellowship program director.
- References should send their letters of recommendation directly to the program director.
- If internationally trained or citizenship is not US, please attach copies of your Visa or Permanent Resident card and ECFMG certificate.
- Copies of USMLE scores are required