

APPLICATION FOR MOLECULAR IMAGING FELLOWSHIP
July 1, 2017 – June 30, 2018

PERSONAL INFORMATION:

NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY #: XXX - XX - _____

ECFMG CERTIFICATION: _____ VISA STATUS: _____

CITIZENSHIP: _____

E-MAIL: _____@_____

HOME: _____ (____) _____ - _____
ADDRESS/STREET CITY STATE ZIP HOME TELEPHONE

HOSPITAL: _____ TELEPHONE: (____) _____ - _____
NAME OF INSTITUTION

ADDRESS/STREET CITY STATE ZIP

EDUCATIONAL INFORMATION:

COLLEGE DEGREE: _____ NAME OF SCHOOL: _____ YR. GRAD. _____

M.D. DEGREE FROM (NAME OF SCHOOL): _____ YR. GRAD. _____

INTERNSHIP _____ YR: _____ TO _____
SPECIALTY INSTITUTION

RESIDENCY _____ YR: _____ TO _____
SPECIALTY INSTITUTION

OTHER EDUCATION _____ YR: _____ TO _____
SPECIALTY INSTITUTION

USMLE ID#: _____

STEP I: _____ STEP II: _____ STEP III: _____

PLEASE INCLUDE HONORS, AWARD, & PUBLICATIONS ON YOUR CURRICULUM VITAE.

ATTACH PHOTO
HERE

Signature: _____

PLEASE SUBMIT THE FOLLOWING:

1. C.V.
2. THREE (3) LETTERS OF REFERENCE
(ONE LETTER FROM A RADIOLOGIST IS DESIRABLE, BUT NOT REQUIRED)
3. LETTER FROM YOUR RESIDENCY PROGRAM DIRECTOR
4. A BRIEF PARAGRAPH DESCRIBING YOUR:
 - a. REASONS FOR INTEREST IN MOLECULAR IMAGING
 - b. TRAINING EXPECTATION
 - c. PRACTICE EXPECTATIONS
5. COPIES OF:
 - a. MEDICAL SCHOOL TRANSCRIPT (USMLE) STEP 1 RESULTS ARE MANDATORY
 - b. MEDICAL SCHOOL DIPLOMA
 - c. INTERNSHIP CERTIFICATE
 - d. USMLE TRANSCRIPT
5. PHOTO

PLEASE DIRECT ALL CORRESPONDENCE TO:

HEATHER WEBB, MD, Program Director
C/O Mia Raymond, Coordinator
Molecular Imaging Fellowship
Baylor University Medical Center
3500 Gaston Avenue
Dallas, TX 75246