



University of California, Irvine • School of Medicine
Department of Radiological Sciences
Application for Fellowship

Starting Date:									
Subspecialty Programs (Please check all programs of interest):									
<input type="checkbox"/> Abdominal Imaging <input type="checkbox"/> Breast Imaging <input type="checkbox"/> Cardiovascular and Thoracic Imaging <input type="checkbox"/> Musculoskeletal Radiology <input type="checkbox"/> Neuroradiology									
Name:	Last			First			Middle		
Date of Birth:				Gender:			NPI Number:		
Present Address:									
Permanent Mailing Address:									
Telephone (Home):				Telephone (Cell):					
Email:									
U.S. Citizen:		<input type="checkbox"/> Yes <input type="checkbox"/> No		City/State/Country of Birth:					
VISA Type:		Expiration Date:			Other:				
Licensure:	State *California	Number		Date Issued		Expiration Date			
	State	Number		Date Issued		Expiration Date			
	State	Number		Date Issued		Expiration Date			
Fluoroscopy Supervisor and Operator Permit Number				<input type="checkbox"/> Currently do not have Fluoroscopy S&O Permit <input type="checkbox"/> Applied for permit on _____					
Education:	School/Hospital		Location/Address		Dates Attended From/To		Degrees/Type of Specialty		
Residency									
Internship									
Medical School									
Undergraduate									
Other									
Name of Residency Program Director:									



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Employment:					
Company	Job Title	Dates of Employment	Currently Employed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Company	Job Title	Dates of Employment	Currently Employed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Company	Job Title	Dates of Employment	Currently Employed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
USMLE Step 1	Dates Taken & Results	USMLE Step 2	Dates Taken & Results	USMLE Step 3	Dates Taken & Results
LMCC Exam	Dates Taken & Results	ECFMG Exam	Dates Taken & Results		
References (Please list the names and institutions of three supervisors/physicians who will be writing letters for you)					
Name	Title	Institution	Contact Number/Email		
Name	Title	Institution	Contact Number/Email		
Name	Title	Institution	Contact Number/Email		

Do you have any physical conditions which may limit your ability to perform the job applied for?

- Yes If yes, please explain: _____
 No

How did you hear about our program?

Please note that at time of matriculation, it is mandatory to have a valid California Medical License, as well as a State of California Radiography and Fluoroscopy Supervisor and Operator Permit, to participate in the fellowship program.

For further information on the application process for a State of California medical license and State of California Radiography and Fluoroscopy Supervisor and Operator Permit, please see the [Medical Board of California](#) website and the California Department of Public Health [Radiologic Health Branch](#) website.

I agree to meet the California State Licensing and Fluoroscopic certification requirements prior to entering the program. Failure to comply may result in dismissal from the program.

Signature of Applicant: _____ Date: _____

Type/Print Name of Applicant: _____