THE UNIVERSITY of TENNESSEE

Methodist Healthcare

Radiology Residency

Application for Breast Imaging Fellowship

List below the names and addresses of three professional references, at least one of whom is a medical college faculty reference.

REFERENCES	NAME	ADDRESS	YEARS ACQUINTED
1.			
2.			
3.			

In signing this application the physician submitting hereby certifies that to the best of (his/her) knowledge the information given is true. Appointments are contingent on the successful completion of the applicant's current year of graduate medical training and the University of Tennessee Health Science Center appointment process.

Dates this _____ day of _____, 20 ____, at (city, state) _____

Signed: _____

MAIL COMPLETED APPLICATION TO: Fellowship Director, Jenny Boals, MD,
1661 International Place Drive, Suite 350, Memphis, TN 38120
> email: boalsj@memrad.net

FORM: UTMRPCAPP1 (rev. 02/08)

THE UNIVERSITY of TENNESSEE

Methodist Healthcare Methodist Healthcare

PLEASE ATTACH HERE A SMALL RECENT PHOTOGRAPH

Application for Breast Imaging Fellowship

DATES OF PROPOSED TRAINING

TO

NAME(Last, First, Middle) | SEX

MAILING ADDRESS | EMAIL ADDRESS(es)

PERMANENT ADDRESS | TELEPHONE NUMBER(s)

SOCIAL SECURITY NUMBER | AGE | DATE OF BIRTH | PLACE OF BIRTH

U.S. CITIZEN? ☐ YES ☐ NO | IF NOT, CITIZEN OF WHAT COUNTRY?

TYPE OF VISA ON WHICH YOU ENTERED/YOU WILL ENTER THE UNITED STATES (EDUCATION, IMMIGRANT, OTHER)

ECFMG NUMBER AND RESULTS (ATTACH COPY OF CERTIFICATE) | VISA QUALIFYING EXAMINATION? (ATTACH COPY OF RESULTS)

HAVE YOU ENTERED/WILL YOU ENTER THE UNITED STATES UNDER THE EXCHANGE VISITOR PROGRAM? ☐ YES ☐ NO

IF NOT, GIVE THE NAME OF SPONSOR

MARITAL STATUS | NAME OF SPOUSE | ADDRESS

IF NOT MARRIED,NAME OF NEAREST KIN | ADDRESS

MILITARY STATUS (DATES OF SERVICE OR DRAFT CLASSIFICATION)

CURRICULUM VITAE	INSTITUTION	DATES	DEGREE	MAJOR SUBJECT	HONORS
COLLEGE					
POST GRADUATE					
MEDICAL COLLEGE **					

Please submit official transcripts from all medical schools attended and send directly to the Fellowship Coordinator.

** Graduates of medical colleges outside the United States or Canada must present credentials acceptable to the University of Tennessee Health Science Center and the Educational Council for Foreign Medical Graduates and must submit their test scores before this application will be processed. **CONTACT:** Educational Council for Foreign Medical Graduates, 3624 Market Street, Philadelphia, PA 19104.

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Methodist Healthcare

POST GRADUATE HOSPITAL TRAINING

FIRST POST GRADUATE YEAR OR INTERNSHIP HOSPITAL (NAME, ADDRESS)

SPECIALTY

DATES **TO**	CHIEF OF SERVICE OR STAFF

RESIDENCY HOSPITAL (NAME, ADDRESS)

DATES **TO**	TYPE OF RESIDENCY
	CHIEF OF SERVICE

ADDITIONAL HOSPITAL TRAINING (NAME, ADDRESS)

DATES **TO**	TYPE OF TRAINING
	CHIEF OR PRECEPTOR

Attach to this application a list of your scientific publications and a short description of any research experience which you have had prior to, during and after your medical education, including the name of the preceptors.

On the same sheet, please list any honor society memberships, scholarships, honorary fellowships or awards which you have received, including the field of interest, stipends and dates of each.

PLEASE INDICATE THE EXAMS YOU HAVE TAKEN:

- ☐ NBME, Part I
- ☐ NBME, Part II
- ☐ NBME, Part III
- ☐ USMLE, Step I
- ☐ USMLE, Step II
- ☐ USMLE, Step III
- ☐ Flex I
- ☐ Flex II

Please attach copies of exam results

LICENSE NUMBER (ATTACH COPY OF LICENSE)

PLEASE LIST ALL STATE MEDICAL LICENSES ACTIVE AND INACTIVE

DID YOU BELONG TO ANY UNDERGRADUATE SOCIETIES IN MEDICAL COLLEGE? IF SO, PLEASE LIST THEM.

ARE YOU A DIPLOMATE OF THE NATIONAL BOARD OF EXAMINERS?

☐ YES ☐ NO

WHAT EMPLOYMENT POSITIONS HAVE YOU HELD OUTSIDE THE FIELD OF MEDICINE? INCLUDE DATES.