Application for Fellowship

Subspecialty Program_____

Starting Date _____

At RHODE ISLAND HOSPITAL, PROVIDENCE, RHODE ISLAND
A Warren Alpert Medical School of Brown University Affiliated Hospital

NAME_____ DATE OF BIRTH_____
last first middle

ADDRESS_____ Telephone (Home)_____

_____ Telephone (Work)_____

E-Mail _____ Pager #_____

CITIZENSHIP_____

VISA STATUS: (J1, H1, F1, etc.)_____Expiration Date:_____Permanent Resident?_____Other_____
(proof of visa status must accompany application)

EDUCATION:

PREMEDICAL COLLEGE_____DEGREE _____YEAR COMPLETED_____

MEDICAL SCHOOL_____DEGREE_____YEAR COMPLETED_____

If foreign trained, have you taken:

ECFMG EXAM_____where_____date_____certificate no _____

USMLE or LMCC EXAM_____where_____date _____results_____
(copies of ECFMG and USMLE must be included)

RADIOLOGY CORE EXAM

Date_____Results_____

STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE

STATE_____License #_____Expiration Date _____

Have you ever been denied or lost a state license? If yes, explain why.

TRAINING:

1st Post-Graduate year (Internship):

Hospital _____type of training _____dates_____

Other training or hospital research since medical school:
(please list in chronological order, including your present position)

Institution_____
name address type of training dates

_____

_____

REFERENCES: please list the names and institutions of three physicians who will be writing letters for you

_____

_____

_____

Date._____(Signed)_____

Please send this cover sheet with a copy of your CV and a personal statement to the fellowship director at the address specified by the program. One of the letters of recommendation must be from your program director. Please note some programs, in addition, require copies of your Dean's letter, USMLE transcript and/or proof of graduation from medical school.