

Department of Radiology

Application for Admission

Note: Photocopy the completed application for your files. Please notify the Graduate Medical Education office (312/503-7975) and the Department of Radiology (847/570-2477) of any change in your address or phone number.

Date of application	Date program to begin
---------------------	-----------------------

PGY level				
<input type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/> Higher	<input type="checkbox"/> Fellowship

Please type or print legibly.

Personal Data

Name: Last	First	Middle	Social Security No. - -	Date of birth
------------	-------	--------	----------------------------	---------------

Mailing address: Number and Street	City	Mailing address current until Mo. Day Yr.
------------------------------------	------	--

State	Zip code	Home phone ()	Daytime phone ()	Phone current until Mo. Day Yr.
-------	----------	-------------------	----------------------	------------------------------------

Permanent address: c/o Name	Permanent phone ()
-----------------------------	------------------------

Number and street	City	State	Zip code
-------------------	------	-------	----------

E-mail address	Citizenship status	Foreign applicants, specify type of visa you hold.
----------------	--------------------	--

Matriculation Data

Medical school	Location	Degree	Mo.	Yr.
----------------	----------	--------	-----	-----

Programs Offered

NorthShore University HealthSystem

NRMP Code 2090

Fellowship

- Advanced Cardiovascular Imaging & Research Training Program
- Body Imaging Fellowship
- Magnetic Resonance Imaging Fellowship
- Musculoskeletal Imaging Fellowship

Education *List all schools attended.*

Institution	Dates attended		Degree conferred	
	From Mo./Yr.	To Mo./Yr.	Type	Date
Include full name and location				
Undergraduate	/	/		
	/	/		
Medical school			M.D.	
	/	/		
Graduate work (doctoral or master's)				
	/	/		

Graduate Medical Education *Include current and previous graduate medical education.*

Postgraduate experience (resident or fellow)	Dates attended		Name of program supervisor
All previous years of approved and credited postgraduate medical education must be documented by each institution.	From Mo./Yr.	To Mo./Yr.	
PGY I - Type	/	/	
Name and address of institution			
PGY II - Type	/	/	
Name and address of institution			
PGY III - Type	/	/	
Name and address of institution			
PGY IV - Type	/	/	
Name and address of institution			

Other Medical Experience *Include experience such as private practice, hospital and staff appointments, research and military.*

Type	Location	Dates / to /
Type	Location	Dates / to /
Type	Location	Dates / to /

Career Objectives

Please write an autobiographical statement on a separate sheet of paper that explains how you became interested in the specialty or specialties you have chosen. Remember to sign your name and include the date.

Include in your statement

1. A list of scientific papers (published or in preparation)
2. Memberships in honorary, scientific, and professional societies
3. Military status and any military experience that can be used for credit toward specialty board certification requirements
4. Information about time gaps from the date of conferral of medical degree to present
5. Health information or other particulars that you may wish to discuss with the director of the residency or fellowship program of your interest

Interviews

Personal interview date(s) preferences

1. _____
2. _____
3. _____

Always phone the office of the program director before your arrival in Chicago to confirm any interview date and to assure that your application is complete. You may be asked to bring a photograph.

Letters of Recommendation Requested *Include full name and address of institutions.*

Residency program director

1. _____

Faculty member

2. _____

Faculty member

3. _____

Faculty member

4. _____

Examinations Taken *Photocopies of original documents with scores and dates must accompany the application.*

U.S./Canadian medical school graduates					Foreign medical school graduates				
USMLE	Step 1	Step 2	Step 3	USMLE	Step 1	Step 2	Step 3		
Dates taken				Dates taken					
Scores				Scores (min. 80)					
ABR exams					FMGEMS no.				
	Physics	Written	Oral	FMGEMS exam	Basic Science	Clinical Science	English		
Dates taken				Dates taken					
Scores				Scores (min. 80)					
FLEX					FLEX				
Location	Date	Score		Location	Date	Score			
Are you participating in the NRMP Match? <input type="checkbox"/> Yes <input type="checkbox"/> No					ECFMG certificate Date No.				
Licensure (temporary permit, full/complete)					TOEFL		CSA		
State	Number	Date granted	Type	Exp Date	Date	Score	Date	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	
State	Number	Date granted	Type	Exp Date	Current visa status: Entry Date		Expiration Date		
State	Number	Date granted	Type	Exp Date	Type of visa		Visa no.		

Have you ever been convicted of a felony? Yes No (*If yes, please explain on a separate sheet of paper.*)

The information I have given in this application is current and complete to the best of my knowledge.

Signature

Date