UNIVERSITY OF CALIFORNIA, DAVIS

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UC DAVIS MEDICAL CENTER
DIVISION OF CARDIOVASCULAR MEDICINE
4860 Y STREET, SUITE 2820
SACRAMENTO, CA 95817
Phone (916) 734-3764
Fax (916) 734-8394

SCHOOL OF MEDICINE

APPLICATION FOR POSTGRADUATE INTERVENTIONAL FELLOWSHIP

1. Name: _____

2. Desired Starting Date: _____

3. Address: _____

_____

Phone Number: _____

Pager: _____

Email Address: _____

4. Licensed to practice in the following states:

	State	License number	Valid through (MM/YY)
a.	_____	_____	_____
b.	_____	_____	_____

5. Has your medical license ever been suspended, revoked, or involuntarily terminated? YES ☐ NO ☐

If yes, please explain:

6. Are you board certified? YES ☐ NO ☐

Board Name _____

7. E.C.F.M.G. Certification (for graduates of other than U.S. or Canadian medical schools only)

Certificate Number: _____ Expiration date: _____

8. If you are not a citizen of the United States, do you have the legal right to remain and work in the U.S.?

YES ☐ NO ☐ NOT APPLICABLE ☐

Visa Status: Permanent Resident ☐ J-1 ☐

9. Have you ever been named in a malpractice case? YES ☐ NO ☐

If yes, please explain:

10. Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges? YES ☐ NO ☐

If yes, please explain:

11. Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, please explain:

12. College and Address:

Dates of Attendance:

Degree Obtained:

Date of Graduation:

13. Medical School and Address:

Dates of Attendance:

Degree Obtained:

Date of Graduation:

14. Internship (institution and address):

Date of Attendance:

Specialty:

15. Residency (institution and address):

Dates of attendance:

Specialty:

Date of Graduation:

16.Additional postgraduate training:

Dates of attendance:

Specialty:

Date of Graduation:

17. Private practice of medicine (location and dates), if applicable:

18. Honors and awards received (give details):

19. Research Experience (including publications)

20. Membership in professional societies (You may exclude any societies which would indicate race, religion, sex, marital status, age, color, national origin or physical handicap)

21. Why do you want to go into the field of cardiology?

22. How important do you perceive research training to be in terms of your career objectives?

23. What would you like to do immediately after your fellowship training period?

CHARACTER REFERENCES (from whom letters of recommendation may be expected):

Applicant should request a letter of recommendation from your current or last training director and two additional faculty or physicians who have supervised your work.

24. Name: _____ Institution: _____

Position or Title: _____ Address: _____

Phone Number: _____ _____

Number of Years Known to Applicant: _____

25. Name: _____ Institution: _____

Position or Title: _____ Address: _____

Phone Number: _____ _____

Number of Years Known to Applicant: _____

26. Name: _____ Institution: _____

Position or Title: _____ Address: _____

Phone Number: _____ _____

Number of Years Known to Applicant: _____

LIST OF REQUIRED ATTACHMENTS:

A) Personal Statement
B) Current Curriculum Vitae
C) Copy of ECFMG Certificate (if applicable)
D) Three letters of recommendation
E) Copy of your current medical license

APPLICANT SIGNATURE

_____ _____

Name Date:

Mail completed package to:

Jason Rogers, M.D.
Director, Interventional Fellowship Training Program
University of California, Davis Medical Center
4860 Y Street, Suite 2820
Sacramento, CA 95817