

EDUCATION HISTORY

Institution and Address:	Dates Attended Mo/Year	Major/Training	Degree
Undergraduate Education:	From: To:		
Medical School:	From: To:		
Other Postgraduate Education: (please list) 1.	From: To:		
2.	From: To:		
3.	From: To:		

TRAINING

Clinical Training—Includes Internships, Residency, and Fellowship, etc. (please list):	Dates Attended Mo/Year	Specialty	Completed?
	From: To:		
	From: To:		
	From: To:		
	From: To:		

RESEARCH AND OTHER EXPERIENCE

Institution and Addresses	Dates Attended Mo/Year	Specialty	Completed?
Research Experience: 1.	From: To:		
2.	From: To:		
3.	From: To:		
Other Experiences—i.e., military service, private practice, etc. 1.	From: To:		
2.	From: To:		
3.	From: To:		

BOARD CERTIFICATION (Must be Board eligible)

Type and Date:

LIST STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE:

GRADUATES OF FOREIGN MEDICAL SCHOOLS - Please state ECFMG status, number and date and attach a copy of your ECFMG certificate.

HONORS, SCHOLARSHIPS, FELLOWSHIPS, AND/OR GRANTS RECEIVED
(please list)

MEMBERSHIP(S) IN PROFESSIONAL SOCIETIES
(please list)

PUBLICATIONS

Please submit representative publications (optional)

REFERENCES:

Please request a letter from **the Dean of your medical school along with your grade transcripts**; a letter of recommendation from the Chair or Director of your radiology residency program; and two additional letters from physicians of your choice. Each person should address his or her letter directly to the Director of the Fellowship Program. It is the applicant's responsibility to see that these letters arrive in a timely fashion. Also, please include a current CV.

Name and Address of Dean of Medical School:	Name and Address of Director of Radiology:

Name, Address and Title of other persons from whom letters are requested:	
1. 	2.

Applications and letters of recommendation should be mailed to:

Tracey Brown, Fellowship Coordinator for:
Department of Radiology, University of California, Davis
Lawrence J. Ellison Ambulatory Care Center (ACC)
4860 Y Street, Suite 3100
Sacramento, California 95817
e-mail address: tracey.brown@ucdmc.ucdavis.edu
ph (916) 703-2273 fax (916) 703-2274

Applicants are urged to submit their applications and related items by October 1st, two years prior to the year in which the fellowship begins. Selection for interview is based on careful review of application, CV, letters of recommendation, USMLE scores and transcriptions, and personal statement, by the Director of the fellowship program.

Signature: _____ Date: _____

Please Print Name: _____

Social Security Number: _____

Date of Birth: _____

California Medical License #: _____

Date of Issuance: _____ Expiration Date: _____