

APPLICATION FOR FELLOWSHIP

FELLOWSHIP START DATE _____

1. _____
Last name (type or print) First name Middle initial

2. _____
Home address City State Zip Country

3. _____
Professional address Department

City State Zip Country

4. _____
Home Phone Work Phone

5. _____
Social Security # Date of Birth

6. _____
Emergency contact Relationship Telephone

7. _____
E-mail address

8. Licensed to practice medicine in the State/Province _____ License # _____

9. EDUCATION

a. High School _____
Name Location Degree Date

b. College _____
Name Location Degree Date

c. Medical School _____
Name Location Degree Date

d. Internship _____
Hospital Location Type Dates

e. Residency _____
Hospital Location Type Dates

f. 2nd Residency or Fellowship _____
Hospital Location Type Dates

10. Please enclose a curriculum vitae including your publications, scientific exhibits and honors in medicine. You must also request a copy of your medical school transcript.

For identification purposes only, please provide a small photograph.

11. REFERENCES: Names of **three** diagnostic radiologists who will be writing letters of recommendation for you. At least one of these radiologists should be a pediatric radiologist. These three letters should be mailed to Dr. Sena.

a. _____
Name Hospital

Address City State Zip

b. _____
Name Hospital

Address City State Zip

c. _____
Name Hospital

Address City State Zip

12. IF YOU ARE NOT A CITIZEN OF THE UNITED STATES:

What type of visa will you hold while you are at Children's Hospital? _____

If you are in the U.S. on an Exchange Visitor Program, give the name and program number of your current sponsor:

13. A graduate of a foreign medical school (except Canada) who will have any clinical responsibilities is required to pass the United States Medical Licensing Exam (USMLE).

If you are certified, indicate below:

Standard Certificate: Number _____ (copy must be included)

Interim Certificate: Number _____ (copy must be included)

Date of passing USMLE: _____

Signature of Applicant _____

Date _____

FELLOWSHIP APPLICATION CHECKLIST

- Completed application
- Medical school transcript
- Three letters of recommendation from radiologists
- Updated curriculum vitae
- Small photograph for identification purposes only

RETURN COMPLETED APPLICATION TO:

LAUREEN SENA, M.D.
FELLOWSHIP PROGRAM CO-DIRECTOR
DEPARTMENT OF RADIOLOGY
CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115
PHONE: (617) 355-6428
FAX: (617) 730-0549
LAUREEN.SENA@CHILDRENS.HARVARD.EDU