Boston Children's Hospital
Department of Radiology

HARVARD MEDICAL SCHOOL
Department of Radiology

# APPLICATION FOR PEDIATRIC INTERVENTIONAL RADIOLOGY FELLOWSHIP

Anticipated Start Date: _____

## GENERAL INFORMATION

Name: _____
Last Name First Name Middle Name

Current Address: _____
Street City State/Country Zip Code

Email Address: _____

Telephone Numbers: _____
Home Work Mobile

Citizenship Status: ☐ US Citizen ☐ Permanent Resident ☐ J-1 visa ☐ H-1B Visa

## EDUCATION

Undergraduate

College/University: _____

City and State/Country _____

Dates Attended: _____ Degree: _____ Major: _____

Medical School

College/University: _____

City and State/Country _____

Dates Attended: _____ Degree: _____ Major: _____

ECFMG Number: _____ Issue Date: _____

## EXAMINATIONS

USMLE

Step 1: Date: _____ Status: _____
Step 2 CK: Date: _____ Status: _____
Step 2 CS: Date: _____ Status: _____
Step 3: Date: _____ Status: _____

Other Examinations:

Name of Exam: _____ Date: _____ Status: _____

Name of Exam: _____ Date: _____ Status: _____

**SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____**

## PRIOR TRAINING

Internship

Institution: _____

City and State/Country: _____ Dates Attended: _____

Completed Program: ☐ Yes ☐ No Specialty/Area of Training: _____

Residency

Institution: _____

City and State/Country: _____ Dates Attended: _____

Completed Program: ☐ Yes ☐ No Specialty/Area of Training: _____

Fellowship

Institution: _____

City and State/Country: _____ Dates Attended: _____

Completed Program: ☐ Yes ☐ No Specialty/Area of Training: _____

## REFERENCES

Names of **three(*)** radiologists who will be writing letters of recommendation on your behalf, including at least one letter in the specific area of anticipated fellowship. All letters should be addressed to Dr. Gulraiz Chaudry, Program Director and should be sent to Jane Choura, Fellowship Program Coordinator, Boston Children's Hospital, 300 Longwood Avenue, Boston, MA 02115.

| **Reference #1** | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City | State | Zip/Postal Code |

| **Reference #2** | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City | State | Zip/Postal Code |

| **Reference #3** | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City | State | Zip/Postal Code |

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| **E-Signature of Applicant** | Date |

| **Application Checklist:** | |
|---|---|
| | Completed application |
| | Updated curriculum vitae (CV) |
| | Personal statement |
| | Photo – to be used for identification purposes only |
| | Request medical school transcript |
| | Request 3 letters of recommendation **(*)** |
| | |

SUBMIT COMPLETED APPLICATION TO:

JANE CHOURA
COORDINATOR, FELLOWSHIP PROGRAM
DEPARTMENT OF RADIOLOGY
CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115
PHONE: (617) 355-6290
FAX: (617) 730-0573

**SUBMIT FORM:**