Boston Children's Hospital

Where the world comes for answers

Boston Children's Hospital Pediatric Neuroradiology Fellowship Application

Your Contact Information

Fellowship Start Date: _____

First Name: _____

Middle Initial: _____

Last Name: _____

Degree(s): _____

Home Address: _____

City: _____

State: _____

Zip code: _____

Country: _____

Professional Address: _____

City: _____

State:
_____

Zip code:
_____

Country:
_____

Home Phone:
_____

Work Phone:
_____

Social Security Number:
_____

Email Address:
_____

Date of Birth:
_____

Emergency Contact:
_____

Relationship:
_____

Licensure to Practice Medicine

State/Province:
_____

License #:
_____

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Your Education

Include name, location, and degree date for first 3 items.

High School:

_____

College:

_____

Medical School:

_____

Include hospital, location, type, and dates for next 3 items.

Internship:

_____

Residency:

_____

2nd Residency or Fellowship:

_____

Which Fellowship will you complete prior to Pediatric Neuroradiology Fellowship?

_____

Curriculum Vitae and Personal Statement

1. Please attach curriculum vitae below in pdf or word doc format, including your publications, scientific exhibits, and honors in medicine.
2. You must also request a copy of your medical school transcript.
3. For identification purposes only, please attach a small photograph and upload.
4. Please attach below a one-page personal statement in pdf format

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References:

Names of three diagnostic radiologists who will be writing letters of recommendation for you. These three letters should be addressed to Dr. Joanne Rispoli, Program Director of Pediatric Neuroradiology, Boston Children's Hospital, Department of Radiology, and sent via email to Joanne.Rispoli@childrens.harvard.edu.

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First Name: _____

Last Name: _____

Hospital: _____

Address: _____

City: _____

State: _____

Zip code: _____

First Name: _____

Last Name: _____

Hospital: _____

Address: _____

City: _____

State: _____

Zip code: _____

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_____

Last Name:
_____

Hospital:
_____

Address:
_____

City:
_____

State:
_____

Zip code:
_____

If you are not a citizen of the United States:

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

_____

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

_____

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 sent):

_____

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Interim Certificate Number (Copy must be included):

_____

Date of passing USMLE:

_____

Have you taken and passed the Visa Qualifying Examination (VQE)? (yes or no)

_____

Signature of Applicant:

_____

Date:

_____

Fellowship Application Checklist

- ✓ Completed application
- ✓ Personal statement
- ✓ Medical school transcript
- ✓ Three letters of recommendation from radiologists
- ✓ Small photograph (for identification purposes only)
- ✓ Curriculum Vitae

Please submit your application to Dr. Joanne Rispoli via email. Thank you.

Joanne Rispoli, MD
Director of Pediatric Neuroradiology Fellowship
Boston Children's Hospital, Department of Radiology
300 Longwood Avenue Boston, MA 02115
Email: joanne.rispoli@childrens.harvard.edu