

# Residency/Fellowship Training Application



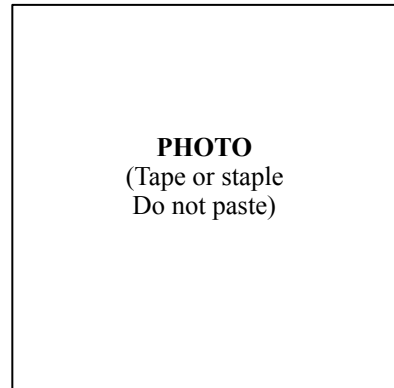
## DEPARTMENT OF RADIOLOGY

The University of Texas Southwestern Medical Center Affiliated Hospitals

- Parkland Health and Hospital System • Dallas Veterans Administration Hospital •
- Children's Medical Center • Zale Lipshy University Hospital •

**Please return application to:**

Christina Thomas, MBA - MHSM  
Department of Radiology  
The University of Texas  
Southwestern Medical Center at Dallas  
5323 Harry Hines Boulevard  
Dallas, Texas 75390-8896



**Contact Information:**

Tel: (214) 648-8022  
Fax: (214)648-2678  
Email: [Christina.Thomas@utsouthwestern.edu](mailto:Christina.Thomas@utsouthwestern.edu)

**Additional requirements:**

- Personal statement and *curriculum vitae*
- Medical School transcript
- Letter from Dean of medical school evaluating your performance
- Three letters of recommendation from full-time faculty members or physicians who have knowledge of your clinical ability

For more information, visit our website at:

<http://www8.utsouthwestern.edu/utsw/cda/dept116602/files/117108.html>

---

**PLEASE COMPLETE ALL SECTIONS OF THIS FORM**

Application for Residency in:  Diagnostic Radiology  Nuclear Medicine

Application for Fellowship in: \_\_\_\_\_

Beginning date: \_\_\_\_\_

Name: \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Present Address \_\_\_\_\_ Telephone No: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP) Daytime No: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Permanent Address \_\_\_\_\_ Telephone No: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP) Email: \_\_\_\_\_

Do you have a Texas Medical License?  Yes  No If Yes, please provide the number: \_\_\_\_\_

If no, FMG Status:  J1  H1-B  EAD

**PREMEDICAL EDUCATION**

	Name Of Institution	City And State	From Mo-Yr.	To Mo-Yr.	Degree/Major
High School					
College					
Graduate School					

**MEDICAL EDUCATION**

Name Of Institution	City And State	From Mo-Yr.	To Mo-Yr.	Degree

**INTERNSHIP OR RESIDENCY TRAINING**

Name Of Institution	City And State	From Mo-Yr.	To Mo-Yr.	Type
Estimated scholastic standing in your class:		Examinations Taken and Scores:		

Honors and Awards (additional information may be attached): \_\_\_\_\_

Hospital, graduate school, or medical research experience you have had (additional information may be attached): \_\_\_\_\_

**Foreign Graduates or Non-Citizens, please complete the following:**

Country of Citizenship: \_\_\_\_\_

Have you passed the ECFMG exam? \_\_\_\_\_ If so, please send copy of certificate.

Visa Status: \_\_\_\_\_ Please send copy of visa.

LIST NAMES OF THOSE WRITING LETTERS OF RECOMMENDATION (three required):


I certify that the statements in this application are true, complete, and correct to the best of my knowledge. I understand that any false statements made herein will void this application and any actions based on it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_