

**DEPARTMENT OF RADIOLOGY  
PEDIATRIC RADIOLOGY DIVISION  
FELLOWSHIP TRAINING APPLICATION**

**The University of Texas Southwestern Medical School Affiliated Hospitals**

Children's Medical Center Dallas

Parkland Memorial Hospital

Dallas Veterans Affairs Medical Center

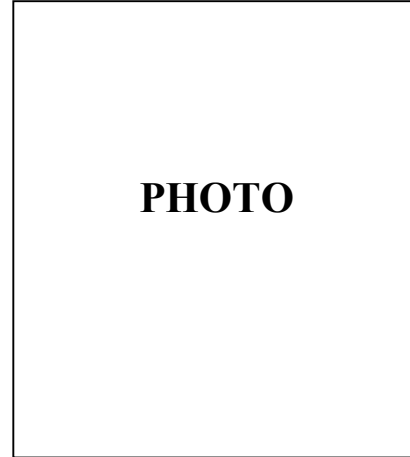
Zale Lipshy University Hospital

Texas Scottish Rite Hospital for Children

**Please return application to:**

**Timothy Booth, MD  
Pediatric Radiology Fellowship Director**

**Children's Medical Center Dallas  
1935 Medical District Drive  
Dallas, Texas 75235-7794  
Telephone: 214-456-6305  
Fax: 214-456-6015**



- 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

**PLEASE COMPLETE ALL SECTIONS OF THIS FORM**

Beginning date of requested fellowship:

Name:

Soc Sec. No:

Present Address:

Telephone:

Daytime phone:

(City) (State) (Zip)

Permanent Address:

Telephone:

Date of Birth:

(City) (State) (Zip)

**PRE-MEDICAL 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/Major

**INTERNSHIP OR RESIDENCY TRAINING**

NAME OF INSTITUTION	City and State	From mo/yr	To mo/yr	Type
<b>Estimated scholastic standing in your class:</b>	MLE Scores:			
	Part I:		Part II:	

Do you have a Texas Medical License?

Number

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: \_\_\_\_\_

Do you have ECFMG? \_\_\_\_\_ If yes, please attach copy.

Visa Status? \_\_\_\_\_ Please send copy of visa

List the names of those writing letters of recommendation (three required):

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

I certify that the statements made 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: \_\_\_\_\_