

Residency/Fellowship Training Application



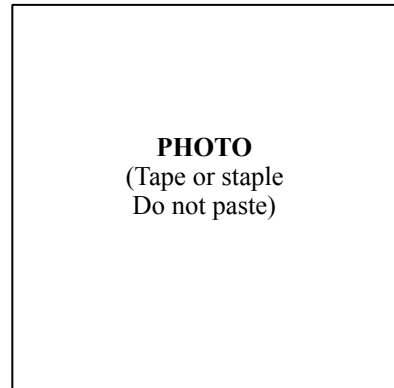
DEPARTMENT OF RADIOLOGY

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:

Tanya S. Washington
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: TanyaS.Washington@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: _____