**Tufts Medical Center Standardized Fellowship Application Coversheet**

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| Applying for: (please circle the relevant choice) | 1. Emergency & Trauma Radiology Fellowship 2. Magnetic Resonance Imaging Fellowship |
| Date of submission: |  |
| Fellowship Begin Date (state which year) | July \_\_\_\_\_\_\_\_\_\_\_\_  Other (MM/YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Applicant Name: |  |
| Citizenship: |  |
| Date of Birth: |  |
| ECFMG Certification: (please circle) | YES (date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_); NO |
| Visa sponsorship: | 1. Not needed 2. J-1 3. H1B 4. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Home Address: |  |
| Telephone number: |  |
| Email: |  |
| Medical School Name and Address: |  |
| Internship (Program Name and Institution Address): |  |
| Radiology Residency (Program Name and Institution Address):: |  |
| Other training completed (or to be completed): |  |
| ABR Board certified | YES (date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_); NO |
| ABR Board eligible | YES (expected date of certifying exam)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referee 1 (Name, Institution, Email, phone number) |  |
| Referee 2 (Name, Institution, Email, phone number) |  |
| Referee 2 (Name, Institution, Email, phone number) |  |

Version 1. Created by DH. 01142024.