



UNIVERSITY of CALIFORNIA, SAN DIEGO

SCHOOL OF MEDICINE Department of Radiology

MRI Visiting Fellowship Program

Last Name: _____ First Name: _____ Degree: _____

Hospital Name: _____

Hospital Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

E-mail: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ E-mail: _____

Please select a session:

- October 5-9, 2009
February 22-26, 2010
April 19-23, 2010
July 19-23, 2010
September 27-Oct 1, 2010

Tuition for the course is \$3000.00 payable by check or credit card
Please make checks payable to UC REGENTS
Tuition is due prior to the start of the program

Credit Card #: _____

Expiration Date: _____

Name on Credit Card: _____

Please complete this form and return to:

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Chairman's Office, Department of Radiology
402 Dickinson St., #454
San Diego, CA 92103-8224
Phone 619-543-2890
Fax 619-543-2889
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(x) _____
Signature