UC San Diego
SCHOOL OF MEDICINE

APPLICATION FOR FELLOWSHIP

Fellowship Year:		Today's Date:	
Subspecialty:			
APPLICANT DATA			
Last Name:	First Name:	Middle Initial:	
Email Address: ***Note: No addresses with .edu, .net, or .org***			
Address:		Country:	
Home Phone:	Cell Phone:	Pager:	
Are you legally authorized to work in the US?	Will you now or in the future require sponsorship for employment visa status? ***(i.e. J-1 visa status)***		
EDUCATION			
Premedical College:	City and State:	Degree:	Completed
Medical School:	City and State:	Degree:	Completed
TRAINING			
Internship Institution:	Type of Training:	Date Range:	
Residency Institution:	Type of Training:	Date Range:	
Fellowship Institution:	Type of Training:	Date Range:	

Other education, training, or hospital research (Please list chronologically, and include your present position):		
Institution Name and Address:	Type of Training:	Date Range:
Institution Name and Address:	Type of Training:	Date Range:
Institution Name and Address:	Type of Training:	Date Range:
Please explain all breaks in service. Attach additional pages, if necessary.		

EXAMS

USMLE of LCC Exams:

Note: Copies of USMLE/LMCC must accompany application.

Step 1	**Step 2CK**	**Step 2CS**	**Step 3**
Date Taken: Result:	Date Taken: Result:	Date Taken: Result:	Date Taken: Result:
COMLEX:	Date Taken:	Result:	Location:

If foreign trained, **do you have ECFMG Certification?** ◯Yes ◯No ◯N/A

Note: Copies of ECFMG must accompany application.

ECFMG Certificate Number:	Year Completed:	Location:

American Board of Radiology Exam

Core: ◯Yes ◯No ◯N/A Date Taken:	Certification: ◯Yes ◯No ◯Other Date Taken: If "other," please explain:

State/s in which you are licensed to practice medicine:

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

REFERENCES			
Physician Name	Title	Institution	Email
1.			
2.			
3.			

Please print and sign the completed application, and include it with your supporting documents.

Signature_____Date_____