University of California, Irvine ▪ School of Medicine
Department of Radiological Sciences
Application for Fellowship

Starting Date:	

Subspecialty Programs (Please check all programs of interest):

- ☐ Abdominal Imaging
- ☐ Abdominal/Breast
- ☐ Abdominal/AI
- ☐ Abdominal/Advanced MR
- ☐ Breast Imaging
- ☐ Cardiovascular and Thoracic Imaging
- Musculoskeletal Radiology
- Musculoskeletal/Interventional Radiology
- Neuroradiology

Name:	Last	First	Middle
Date of Birth:		**Gender:**	**NPI Number:**
Present Address:			
Permanent Mailing Address:			
Telephone (Home):		**Telephone (Cell):**	
Email:			
U.S. Citizen:	☐ Yes ☐ No	**City/State/Country of Birth:**	
VISA Type:		**Expiration Date:**	**Other:**

Licensure:	State *California	Number	Date Issued	Expiration Date
	State	Number	Date Issued	Expiration Date
	State	Number	Date Issued	Expiration Date

Fluoroscopy Supervisor and Operator Permit Number		☐ Currently do not have Fluoroscopy S&O Permit ☐ Applied for permit on _____

Education:	School/Hospital	Location/Address	Dates Attended From/To	Degrees/Type of Specialty
Residency				
Internship				
Medical School				
Undergraduate				
Other				

Name of Residency Program Director:	

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Employment:					
Company	Job Title	Dates of Employment	Currently Employed:	☐ Yes ☐ No	
Company	Job Title	Dates of Employment	Currently Employed:	☐ Yes ☐ No	
Company	Job Title	Dates of Employment	Currently Employed:	☐ Yes ☐ No	

USMLE Step 1	Dates Taken & Results	**USMLE Step 2**	Dates Taken & Results	**USMLE Step 3**	Dates Taken & Results
LMCC Exam	Dates Taken & Results	**ECFMG Exam**	Dates Taken & Results		

References (Please list the names and institutions of three supervisors/physicians who will be writing letters for you)

Name	Title	Institution	Contact Number/Email
Name	Title	Institution	Contact Number/Email
Name	Title	Institution	Contact Number/Email

Do you have any physical conditions which may limit your ability to perform the job applied for?

☐ Yes If yes, please explain: _____
☐ No

How did you hear about our program?

_____

_____

Please note that at time of matriculation, it is mandatory to have a valid California Medical License, as well as a State of California Radiography and Fluoroscopy Supervisor and Operator Permit, to participate in the fellowship program.

For further information on the application process for a State of California medical license and State of California Radiography and Fluoroscopy Supervisor and Operator Permit, please see the Medical Board of California website and the California Department of Public Health Radiologic Health Branch website.

I agree to meet the California State Licensing and Fluoroscopic certification requirements prior to entering the program. Failure to comply may result in dismissal from the program.

Signature of Applicant: _____ Date: _____

Type/Print Name of Applicant: _____