



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

Starting Date:										
Subspecialty Programs (Please check all programs of interest): <div style="display: flex; flex-wrap: wrap; padding: 10px;"> <div style="width: 50%;"> <input type="checkbox"/> Abdominal Imaging <input type="checkbox"/> Abdominal/AI <input type="checkbox"/> Abdominal/Advanced MR <input type="checkbox"/> Breast Imaging </div> <div style="width: 50%;"> <input type="checkbox"/> Cardiovascular and Thoracic Imaging <input type="checkbox"/> Musculoskeletal Imaging and Intervention-UCI <input type="checkbox"/> Musculoskeletal Radiology-LBVA <input type="checkbox"/> Oncological Imaging </div> </div>										
Name:	Last			First			Middle			
Date of Birth:				Gender:				NPI Number:		
Present Address:										
Permanent Mailing Address:										
Telephone (Home):					Telephone (Cell):					
Email:										
U.S. Citizen:	<input type="checkbox"/> Yes <input type="checkbox"/> 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				<input type="checkbox"/> Currently do not have Fluoroscopy S&O Permit <input type="checkbox"/> Applied for permit on _____						
Education:	School/Hospital		Location/Address		Dates Attended From/To		Degrees/Type of Specialty			
Residency										
Internship										
Medical School										
Undergraduate										
Other										



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Name of Residency Program Director:						
Employment:						
Company		Job Title		Dates of Employment		
				Currently Employed:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Company		Job Title		Dates of Employment		
				Currently Employed:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Company		Job Title		Dates of Employment		
				Currently Employed:	<input type="checkbox"/> Yes <input type="checkbox"/> 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		
Name		Title		Institution		
Name		Title		Institution		

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: _____