

Application for MRI Fellowship

PLEASE MOUNT HERE
A SMALL RECENT
PHOTOGRAPH

Preferred Fellowship: _____

Dates of proposed training _____ to _____

Name (Last, First, Middle) _____ Sex _____

Mailing Address _____ Telephone Number _____

Permanent Address _____ Telephone Number _____

Social Security Number _____ Age _____ Date of Birth _____ Place of Birth _____

U.S. Citizen Yes No If not, citizen of what country? _____

Type of visa on which you have entered/you will enter the United States (Education, Immigrant, Other) _____

ECFMG Number and results (Attach copy of certificate) _____ Visa Qualifying Examination? (Attach copy of results) _____

Have you entered/will you enter the United States under the Exchange Visitor Program Yes No

If not, give name of sponsor _____

Can you perform the essential functions of your residency position with or without reasonable accommodation? Yes No

If No, Please Explain _____

Marital Status _____ Name of spouse _____ Address _____

If not married, name of nearest of kin _____ Address _____

Military Status (Dates of Service or Draft Classification) _____

Curriculum Vitae	Institution	Dates	Degree	Major Subject	Honors
College					
Post Graduate					
** Medical College					

** Graduates of medical colleges outside the United States or Canada must present credentials acceptable to the Thomas Jefferson University Hospital and Educational Council for Foreign Medical Graduates and must submit their test scores before this application will be processed.
 Contact: Educational Council for Foreign Medical Graduates, 3624 Market Street, Philadelphia, PA 19104.

Application for Graduate Training

Post Graduate Hospital Training

First Post Graduate year or Internship Hospital (Name, Address)

Specialty

Dates	to	Chief of Service or Staff
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Residency Hospital (Name, Address)

Dates	to	Type of Residency
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Board Credit Years	Chief of Service
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Additional Hospital Training (Name, Address)

Dates	to	Type of Training
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Board Credit Years	Chief of Preceptor
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Attach to this application a list of your scientific publications and a short description of any research experience which you have had prior to, during and after you medical education, including the names of the preceptors.

On the same sheet please list any honor society memberships, scholarships, honorary fellowships or awards which you have received, including the field of interest, stipends and dates of each.

Please indicate the exams you have taken:

- | | | |
|--|---|--|
| <input type="checkbox"/> NBME, Part I | <input type="checkbox"/> NBME, Part II | <input type="checkbox"/> NBME, Part III |
| <input type="checkbox"/> USMLE, Step I | <input type="checkbox"/> USMLE, Step II | <input type="checkbox"/> USMLE, Step III |
| <input type="checkbox"/> Flex I | <input type="checkbox"/> Flex II | |

Please attach copies of exam results

License Number (attach copy of license)

Do you belong to a county medical society?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which one?
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Did you belong to any undergraduate societies in medical college?

Are you a Diplomate of the National Board of Medical Examiners?

What employment positions have you held outside the field of medicine? Include dates and stipends.



Application of Graduate Training

List below the names and addresses of three professional references, at least one of whom is a medical college faculty reference.

References	Name	Address	Years Acquaintance
1.			
2.			
3.			

In signing this application the physician submitting hereby certifies that to the best of (his/her) knowledge the information given is true. Appointments are contingent on the successful completion of the applicant's current year of graduate medical training, and the Thomas Jefferson University Hospital appointment process.

Dates this _____ day of _____, 20 _____, at (city, state) _____

Signed _____

Mail To: Donald G. Mitchell, M.D. 1096 Main Building 132 South 10th Street, Thomas Jefferson University Hospital, Phila., PA 19107

AREA BELOW NOT TO BE FILLED IN BY APPLICANT

To the Hospital Director:

I am herewith forwarding to you the application of _____
Applicant's Name

for a _____ in _____, to be considered by the House Staff Committee.
Residency/Fellowship Specialty

I hereby recommend acceptance of the above applicant for one year

a. from _____ to _____

b. Stipend to be _____ per annum.

c. Stipend payable form (Name of Fund, Grant, etc.) _____

d. The applicant is a First Second Third Fourth Fifth Sixth year resident

Signed _____

Date _____ Chairman, Department of _____