



University of Nebraska Medical Center Application for Fellowship

Subspecialty Program _____

Starting Date _____

PERSONAL INFORMATION:

NAME _____ DATE OF BIRTH _____
last first middle

ADDRESS _____ TELEPHONE (HOME) _____

_____ TELEPHONE (WORK) _____

EMAIL _____ PAGER # _____

CITIZENSHIP: _____

VISA Type (J1, H1, F1, etc.) _____ Expiration date: _____ Permanent Resident ? _____ Other _____
(proof of visa status must accompany application)

EDUCATION:

PREMEDICAL COLLEGE _____

DEGREE _____ YEAR COMPLETED _____

MEDICAL SCHOOL _____

DEGREE _____ YEAR COMPLETED _____

If foreign trained, have you taken (copies of ECFMG and USMLE must be included):

ECFMG EXAM _____ where _____

date _____ certificate no _____

USMLE or LMCC exam _____ where _____

date _____ results _____

AMERICAN BOARD of RADIOLOGY EXAMS (dates taken and results)

Physics _____ Written _____ Oral _____

OVERSEAS RADIOLOGY EXAMS (dates taken and results)

STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE

STATE _____ License # _____ Expiration Date _____

Have you ever been denied or lost a state license? If yes explain why.

TRAINING:

1st Post Graduate Year (Internship):

Hospital _____ type of training _____ dates _____



Other education, training or hospital research (please list in chronological order, including your present position)

Institution _____
name address type of training dates

REFERENCES: please list the names and institutions of three physicians who will be writing letters for you

Date _____ (Signed) _____

Please send this cover sheet with a copy of your CV and a personal statement to the fellowship director and fellowship coordinator at the address specified by the program. One of the letters recommendations must be from your program director.