

**MRI Radiology Fellowship
APPLICATION FORM**

**Return completed form with a copy of your CV to the program director.
Letters of recommendation should be mailed to the program director.**

Kedar Jambhekar, M.D.
Department of Radiology
University of Arkansas for Medical Sciences
4301 West Markham, #556
Little Rock, AR 72205

Check one:

- 2011-2012
- 2012-2013
- 2013-2014

NAME _____
Last First Middle Initial Degree

CURRENT CONTACT INFORMATION

E-mail _____
Street Address _____
City _____ Country _____
State/Province _____ Zip Code _____
Home phone _____ Work phone _____ Pager _____

CITIZENSHIP/STATUS _____ SSN/SIN _____

BIRTH DATE _____ BIRTHPLACE _____ [This information is required upon acceptance]

EDUCATION

	Dates	Degree
College _____	_____ to _____	_____
Medical _____	_____ to _____	_____
Other _____	_____ to _____	_____
Internship _____	_____ to _____	_____

RESIDENCY PROGRAM

Institution _____
Field _____ Dates _____
Institution _____
Field _____ Dates _____
Other _____

PRESENT EMPLOYMENT _____

HOSPITAL APPOINTMENTS _____

OVERALL CAREER GOALS [practice, academic, etc.] _____

SPECIAL AREAS OF INTEREST [CVNM, GI, etc.] _____

RESEARCH INTERESTS _____

MEDICAL LICENSURE [State/Year] _____

Has your medical license ever been suspended/revoked/voluntarily terminated? Yes _____ No _____
If yes, provide reason _____

Have you ever been named in a malpractice case? Yes _____ No _____
If yes, provide reason _____

Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges?
Yes _____ No _____
If yes, provide reason _____

Have you ever been convicted of a felony? Yes _____ No _____
If yes, provide reason _____

[The applicant may be required to provide additional information and be required to submit for a criminal background check.]

ECFMG STATUS [If the applicant is an international medical graduate, we require documentation of current visa status and a copy of ECFMG certificate] _____

BLS? ____ Exp. Date _____ ACLS? ____ Exp Date _____ PALS? ____ Exp Date _____

AMERICAN BOARD OF RADIOLOGY EXAMS [Provide dates taken and results. If not certified, provide date you intend to take.]

Physics _____ Written _____ Oral _____

REFERENCES [Please list the names and institutions of 3 physicians who will be mailing letters for you.]

1] _____

2] _____

3] _____

ARE YOU WILLING TO COME FOR AN INTERVIEW? _____ WHEN? _____

I hereby declare that the information contained within this application is true and accurate. I understand that supplying misinformation to the questions above is grounds for disciplinary action, including immediate dismissal from the program.

Date _____ [Signed] _____