

**Pediatric Radiology Fellowship  
APPLICATION FORM**

**Return completed form with a copy of your CV to the fellowship director by April 1<sup>st</sup>.  
Letters of recommendation should be mailed to the program director.**

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Check one:

- 2010-2011
- 2011-2012
- 2012-2013

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 \_\_\_\_\_  
[Proof of certifications will be required upon acceptance.]

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] \_\_\_\_\_