

# VIR Radiology Fellowship APPLICATION FORM

Return completed form with a copy of your CV to the fellowship director at either address by April 1. Letters of recommendation should be mailed to the program director.

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NAME \_\_\_\_\_  
Last First M.I. Degree

## CURRENT CONTACT INFORMATION

Preferred E-mail Address: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ Country: \_\_\_\_\_  
State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ 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.] \_\_\_\_\_

ACLS CERTIFIED? Yes \_\_\_\_\_ No \_\_\_\_\_ [Proof of certification 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] \_\_\_\_\_