

**UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER  
APPLICATION FOR FELLOWSHIP IN  
INTERVENTIONAL RADIOLOGY**

**PLEASE PRINT OR TYPE - FILL OUT COMPLETELY**

**PERSONAL INFORMATION**

**Full Name** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Telephone (home)** \_\_\_\_\_

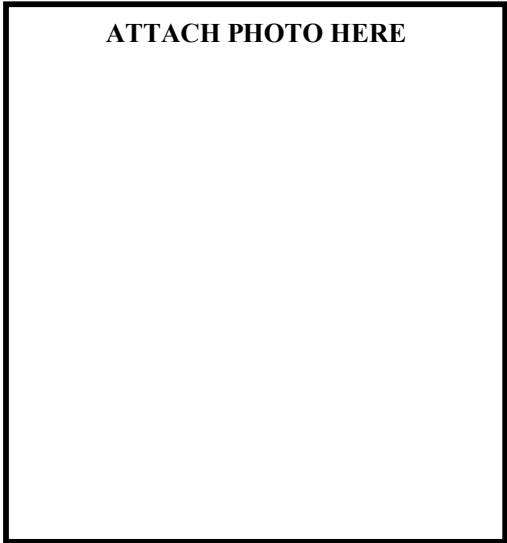
**Telephone (work)** \_\_\_\_\_

**Permanent Address** \_\_\_\_\_  
(if different from above) \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Citizen of USA** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Place of Birth** \_\_\_\_\_ **Ethnic Origin** \_\_\_\_\_  
(optional)

**Marital Status** \_\_\_\_\_ **Name of Spouse** \_\_\_\_\_ **Condition of Health** \_\_\_\_\_



**FOR OFFICE USE ONLY**

**ACADEMIC YEAR:** 2005-2006

**DATE RECEIVED:**

**DATE APPLICATION COMPLETED:**

**INTERVIEW DATE:**

**CONFIRMATION SENT:**

**Premedical Education. Give names of colleges, dates of attendance, degrees\*:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Education. Give names of colleges, dates of attendance, degrees\*:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Internship Served. Name hospital, address and dates\*:** \_\_\_\_\_

\_\_\_\_\_

**Residency/Fellowship training. Name hospital, address and dates\*:** \_\_\_\_\_

\_\_\_\_\_

**Honorary Societies\*:** \_\_\_\_\_

\_\_\_\_\_

**Special training not already listed (assistantships, practice, etc.):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List states you are licensed to practice medicine (include date(s) issued):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Service in armed forces (briefly):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Publications\*:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*USE ADDITIONAL SHEETS IF NECESSARY**

Three letters of reference should be sent by your radiology residency training program professors, including the director of the program. You may also submit more letters of reference from other sources and any other information which you feel may enhance your application.

United States Medical Licensing Examination Scores (required):

Pt I \_\_\_\_\_ Pt II \_\_\_\_\_ Pt III \_\_\_\_\_

Graduates of foreign medical schools must have passed the American Medical Qualification Examination prepared by the Educational Council for Foreign Medical Graduates (ECFMG) before applying for a fellowship in Radiology at the University of Colorado Health Sciences Center. Please enclose a copy of your certificate.

A CV may be attached but not substituted for information requested on this application.

Why are you interested in a fellowship?\*

---

---

---

---

---

Why are you interested in training in this particular Radiology Department?\*

---

---

---

---

---

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**MAIL APPLICATION TO:STEPHEN P. JOHNSON, M.D., DIRECTOR  
INTERVENTIONAL RADIOLOGY/FELLOWSHIP PROGRAM  
UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER  
4200 EAST NINTH AVENUE – CAMPUS BOX A030  
DENVER CO 80262**

**PHONE: (303) 372-6141  
FAX: (303) 372-6234**

\*USE ADDITIONAL SHEETS IF NECESSARY