Application for
Fellowship Training Program

Russell H. Morgan Department of Radiology and Radiological Science

Musculoskeletal Radiology Fellowship

Mail application and correspondences to:

The Johns Hopkins Hospital
Department of Radiology
601 N. Caroline Street
JHOC Room 3014
Baltimore, MD 21287
Attn: Kenya Ervin

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Fax: 410-955-6548
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Program Director:
Shivani Ahlawat, M.D.

☐ **Musculoskeletal Radiology**

Updated June 2015

Johns Hopkins Medicine
Department of Radiology
Fellowship starting: 07/01/ _______

Instructions: Complete all sections (please print or type all responses). If a section does not pertain to you, mark as N/A (not applicable). Do not leave any section blank nor make reference to an attached CV.

1. Name: Last ______________ First ______________ Middle ______________

2. Other Name Used: Last ______________ First ______________ Middle ______________

3. Social Security Number: ______________ Date of Birth: ______________

4. Current/Local Address (include Street, City, State, Zip code): ______________

5. Current/Local Telephone Number: ______________

6. Permanent Address: (include Street, City, State, Zip code) ______________

7. Emergency Contact

Name:	Relationship:	Mailing Address:	Telephone Number:

8. E-Mail Address: ______________

9. Citizenship: Are you a citizen of the United States? ☐ Yes ☐ No If no, complete the following.

Citizenship: ______________ Visa Type: ______________

Entrance Date into U.S.A: ______________ Length of Stay Valid to: ______________

Do you have INS permission to work? ☐ Yes ☐ No

Do you have INS permission to be involved in direct patient care? ☐ Yes ☐ No

Is your degree of patient care involvement limited by your visa? ☐ Yes ☐ No

10. Current Position or Scientific Activities:

Applicant's Name (printed): ____________________

11. College(s) Attended (undergraduate education):

Name(s) of School: ____________________

Mailing Address: ____________________

Month/Years Attended: ____________________ Degree(s) Conferred: ____________________

(Use continuation sheet, if necessary)

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12. Professional Education (medical school) or other doctoral program:

Name(s) of School: ____________________

Mailing Address: ____________________

Month/Years Attended: ____________________ Degree(s) Conferred: ____________________

(Use continuation sheet, if necessary)

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13. For international Medical School Graduates: ECFMG No.: ____________________ Valid to: ____________________
(Provide a copy of your certificate)

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14. Internship, Residencies, Other Postdoctoral Training & Fellowship Programs:

Internship: ____________________

Mailing Address: ____________________

Dates Attended (Month/Years): ____________________ Service or Subject: ____________________

Residency: ____________________

Mailing Address: ____________________

Dates Attended (Month/Years): ____________________ Service or Subject: ____________________

Other: ____________________

Mailing Address: ____________________

Dates Attended (Month/Years): ____________________ Service or Subject: ____________________

(Use continuation sheet, if necessary)

Applicant's Name (printed): ______________________

15. National Board of Medical Examiners:

Diploma: ☐ Yes (attach copy) Date: ____________ ☐ No

Board Scores for NBME: Part I ____________ Part II ____________

USMLE Scores: Step I ____________ Step II ____________ Step III ____________

Clinical Skills Assessment Test Scores: ______________________

16. Hospital Appointments (other than what is included in your training program): List chronologically, appointments to other hospital staffs showing name of hospital, mailing address of hospital, type of appointment (e.g. Active, Moonlighter, OPD, etc.)

Name(s) of Hospital: ______________________

Current Mailing Address: ______________________

Dates of Appointment: ____________ Type of Appointment: ____________

Name(s) of Hospital: ______________________

Current Mailing Address: ______________________

Dates of Appointment: ____________ Type of Appointment: ____________

(Use continuation sheet, if necessary)

17. Teaching Appointments (other than what is included in your training program): List chronologically, any teaching appointments showing name of institution and mailing address of institution.

Name of Institution: ______________________

Current Mailing Address: ______________________

Dates of Appointment: ____________ Type of Appointment: ____________

Name of Institution: ______________________

Current Mailing Address: ______________________

Dates of Appointment: ____________ Type of Appointment: ____________

(Use continuation sheet, if necessary)

Applicant's Name (printed): ______________________________

18. Please explain any gaps in time/ interrupting in clinical training and/or appointments since receipt of medical or professional degree. Any gap of one month or more must be explained.

(Use continuation sheet, if necessary)

19. Licensure: List any health occupation license or registration ever held, showing state(s), country(ies), number(s), date(s), and status.

20. Please be sure to include all Member or Fellow of (e.g., AMA, ACS, etc.) past or present memberships; awards and honors received; scientific or clinical interest; publications; and languages spoken on your CV.

21. Medical References (for clinical applicants): Names and addresses of three (3) physicians who have worked extensively with you or have been responsible for professional observation of you. Do not list: relatives by blood or marriage; the Chief of Service to which you are applying; persons in current training program with you; nor persons who cannot attest to your current level of clinical competency, technical skill, and medical knowledge.

1. Name ______________________ Mailing Address: ______________________ Day-time Telephone ______________________ Fax Number: ______________________

2. Name ______________________ Mailing Address: ______________________ Day-time Telephone ______________________ Fax Number: ______________________

3. Name ______________________ Mailing Address: ______________________ Day-time Telephone ______________________ Fax Number: ______________________

Applicant's Name (printed): ____________________

Continuation Page: Use this page to document additional information. Copy as necessary.

Applicant's Name (printed): ______________________________

Statement of Applicant:

I fully understand that any significant misstatements in, or omission from, this application may constitute cause for denial of appointment to or summary dismissal from, the Hospital Medical Staff and/or The John Hopkins University.

All information submitted by me in this application is true to the best of my knowledge and belief.

I authorize the Hospital and/or the University and their representatives to consult with other hospitals and institutions and their representatives and others, in regard to this application.

I release from liability the Hospital and/or University, their representatives and agents for their actions or omissions performed in good faith and without malice in evaluating the application as well as those who provide information to Hospital and/or University in good faith and without malice, and I consent to the release of such information, including other privileged or confidential information.

I consent to the release of information to other hospitals and institutions and persons with a legitimate interest and agree to hold the Hospital and/or the University, their representatives and agents free of liability for their actions performed in good faith as a part of the quality assurance program, the credentialing process, peer review and medical evaluation activities.

I understand that the information required herein is continuing in nature and I agree to provide any changes in the information provided; i.e., address, name, certification and dates, licensure, etc. I agree to furnish, upon request, an update on any information provided in this application.

A copy of the Statement of Applicant may be used as original.

Date: ______________________ Signature: ______________________________

Printed Name: ______________________________

The Johns Hopkins Institutions do not discriminate on the basis of race, color, sex, religion, age, national or ethnic origin, sexual orientation, handicap, veteran status, or any other occupationally irrelevant criteria.

Applicant's Name (printed): ______________________________

The information requested is for statistical purposes only and will not be used during consideration of the application.

1. Date of Birth ______________________

2. Place of Birth ______________________

3. Gender

☐ Male ☐ Female

4. Ethnicity/Race:
(Self-Identification)

A. Ethnicity:

☐ Of Hispanic or Latino Origin (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish cultures or origin regardless of race).

☐ Not of Hispanic or Latino Origin

B. Race:

☐ Black or African American: A person having origins in any of the original groups of Africa.

☐ Asian: Includes persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent (e.g., Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).

☐ American Indian or Alaskan native: Includes persons having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment..

☐ Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ White: Includes persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

5. Marital Status: ______________________

6. Name of Spouse: ______________________

6. Name(s) of Children and Year(s) of Birth: ______________________