MEDICAL COLLEGE OF WISCONSIN, Milwaukee, Wisconsin

Breast Imaging Fellowship Application Form

(Print or Type)

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER

PROGRAM YEAR APPLYING FOR:

GRADUATE YEAR APPLYING FOR (circle one):

G-I, G-II, G-III, G-IV, G-V, G-VI, G-VII

PRESENT ADDRESS: STREET CITY STATE ZIP

PRESENT PHONE NOS:

DAY ( ) EVENING ( )

(NAME AND PERMANENT ADDRESS OF PERSON THROUGH WHOM I CAN ALWAYS BE CONTACTED) (STREET)

CITY STATE ZIP PHONE NO. ( )

DEA CERTIFICATE #	CPR CERTIFICATION DATE	ACLS CERTIFICATION DATE	NPI #
DEA EXPIRATION DATE	CPR CERTIFICATION EXPIRATION DATE	ACLS CERTIFICATION EXPIRATION DATE	NRMP#

UNDERGRADUATE AND GRADUATE EDUCATION

COLLEGE(S)	DATES ATTENDED FROM (MO./YR.)	DATES ATTENDED TO (MO./YR.)	MAJOR(S)	DEGREE IF ANY
A NAME AND ADDRESS CITY STATE ZIP				
B NAME AND ADDRESS CITY STATE ZIP				
C NAME AND ADDRESS CITY STATE ZIP				

MEDICAL EDUCATION

COLLEGE(S)	DATES ATTENDED FROM (MO./YR.)	DATES ATTENDED TO (MO./YR.)	
A NAME AND ADDRESS CITY STATE ZIP			DATE OF GRADUATION DEGREE
B NAME AND ADDRESS CITY STATE ZIP			DATE OF GRADUATION DEGREE

GRADUATE MEDICAL EDUCATION IN U.S. ACCREDITED PROGRAMS

HOSPITAL(S)	DATES ATTENDED FROM (MO./YR.)	DATES ATTENDED TO (MO./YR.)	PROGRAM PROGRAM DIRECTOR
A NAME AND ADDRESS CITY STATE ZIP			PROGRAM PROGRAM DIRECTOR
B NAME AND ADDRESS CITY STATE ZIP			PROGRAM PROGRAM DIRECTOR
C NAME AND ADDRESS CITY STATE ZIP			PROGRAM PROGRAM DIRECTOR
D NAME AND ADDRESS CITY STATE ZIP			PROGRAM PROGRAM DIRECTOR

THE FOLLOWING INDIVIDUALS HAVE BEEN ASKED TO WRITE REFERENCES FOR ME:
One should be your medical school dean. <u>These individuals should send letters directly to the Program Director.</u>

A. NAME & TITLE

INSTITUTION

ADDRESS

B. NAME & TITLE

INSTITUTION

ADDRESS

C. NAME & TITLE

INSTITUTION

ADDRESS

Are you now or have you ever been involved in administrative, professional or judicial proceedings in which malpractice on your part is or was alleged? If yes, give details.

List all convictions for any offense other than minor traffic violations and all pending criminal charges (no applicant will be denied a position because of a conviction for an offense or because of a pending criminal charge which is not substantially related to the circumstances of the position sought.)

Have any disciplinary actions been initiated or are any currently pending against your medical license(s) in any state? _____

Have there been any actions taken against any privileges you currently or previously held? Do you currently hold privileges at any health care institution or agency? (Include name and address)

Any medical license or DEA certificate revoked, suspended, denied, restricted, limited or issued/placed in a probational status or voluntarily relinquished?

CITIZENSHIP

☐ U.S.

☐ OTHER ( )

*VISA STATUS: (IF APPLICABLE)

☐ PERMANENT

☐ TEMPORARY; SPECIFY: ☐ J-1 ☐ H-1 OTHER _____ (SPECIFY)

INTERNATIONAL MEDICAL SCHOOL GRADUATES:

FMGEMS (Basic Medical Science) _____ NUMBER _____ DATE _____ SCORE

FMGEMS (Clinical Science) _____ NUMBER _____ DATE _____ SCORE

ECFMG English Exam _____ NUMBER _____ DATE _____ SCORE

*ECFMG CERTIFICATE: STANDARD ☐ OR INTERIM ☐ _____ DATE ISSUED _____ EXPIRATION DATE

*FIFTH PATHWAY CERTIFICATE: _____ SCHOOL _____ DATE

NATIONAL BOARD OR USMLE EXAMINATION			FLEX EXAMINATION			D. O. EXAMINATION	
NUMBER _____	DATE	SCORE	NUMBER _____	DATE	SCORE	NUMBER _____	DATE SCORE
PART I			PART I				
STEP 1							
PART II			PART II				
STEP 2							
PART III			PART III				
STEP 3							

*MEDICAL LICENSES: STATE: _____ NUMBER: _____ DATE ISSUED: _____ EXPIRATION DATE: _____

STATE: _____ NUMBER: _____ DATE ISSUED: _____ EXPIRATION DATE: _____

NOTE: Wisconsin licensure is required prior to beginning the Breast Imaging Fellowship program.

This application will not be considered complete unless the three reference letters*, CV, Dean's letter* or medical school transcripts*, USMLE Scores (Steps I, II, IICS, III)*, and photo have been received by the Program Director, and all other requested applicable information on this form is provided on this or an accompanying Universal Application.

* Original or certified copies **of** these documents must be presented to MCW, when pertinent, after acceptance, but prior to start of the training program.

The information provided in this application is true and complete.

Signature _____

Date of Application _____

PERSONAL STATEMENT

Professional interests, achievements and plans, including specialty or subspecialty; anticipated geographic practice location; published papers; honors; professional and scientific organization memberships; family, household and personal interests and activities. Any time since graduation from medical school not accounted for on page 2 should be accounted for here. Use additional sheet if necessary.

Signature: _____

Date of Application: _____

RETURN THIS COPY OF COMPLETED APPLICATION TO:

Medical College of Wisconsin
Mary Beth Gonyo, MD, Program Director
c/o Pam Quella
Department of Radiology
9200 W Wisconsin Avenue
Milwaukee WI 53226
Phone: (414) 805-3749
E-mail: pquella@mcw.edu