

**Department of Radiology**  
**Beth Israel Deaconess Medical Center**  
 Fellowship Application

Subspecialty: \_\_\_\_\_ Beginning Mo/Yr: \_\_\_\_\_

Name      First - Middle - Last		Social Security #	
Present Address - Street	City	State	Zip Code
Home/Work Telephone #'s	E-mail address (if applicable)		Date of Birth
Place of Birth	Citizenship	Marital Status	Dependents

List chronologically your college, graduate school and medical school training; internship and residency; and other clinical or research positions.

Mo/Yr	Mo/Yr	College/University/Institution	Degree/Position
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Licensed to practice medicine in the following states:

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## **ADDITIONAL ITEMS TO BE SUBMITTED IN SUPPORT OF YOUR APPLICATION**

- Curriculum vitae.
- Transcript of medical school record.
- A letter of recommendation from the Director of your Radiology Residency Program and two other radiologists you know well.
- A statement expressing your present thoughts on your long range goals and interests in radiology.

Interviews are granted on a selective basis once all of the above items have been received.

**Please send all applications and supporting documents directly to the chief of the appropriate section listed below (unless noted otherwise in fellowship description). Addresses are c/o:**

Department of Radiology/Fellowship Program  
Beth Israel Deaconess Medical Center  
330 Brookline Avenue  
Boston, MA 02215

**Please see our website at [bidmc.harvard.edu/radiology/](http://bidmc.harvard.edu/radiology/). E-Mail comments or questions to [radfellowship@bidmc.harvard.edu](mailto:radfellowship@bidmc.harvard.edu)**