DEPARTMENT OF
Radiology
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE
AND PUBLIC HEALTH

APPLICATION FOR NONACCREDITED FELLOWSHIP

Program _____

Level ____ **Beginning** _____

Name _____
Last First Middle (Former)

Address (present) _____

(permanent) _____

Social Security # _____ Date of Birth: _____

Email Address: _____

EDUCATIONAL EXPERIENCE

	Institution Name & City, State	**Dates Attended From-To (Mo/Yr)**	**Type of Program Degree Received**
Pre-Med			
Medical School			
Internship (1st yr)			
Residency			
Other Experience			

Honors, Publications, etc. _____

_____

National Board Exam Scores: Date / Score

Part I _____/_____
Part II _____/_____
Part III _____/_____

FLEX Exam Date / Score

Part I ____/_____
Part II ____/_____

Graduates of Foreign Medical Schools - Please indicate:

Type of Visa _____
ECFMG Cert. No. _____
FMGEMS Exam Results _____
English Exam Results _____

Medical Licensure (required): Wisconsin # _____; Other State _____

Have there been any claims for medical malpractice made against you or your insurance carrier? _____
If yes, please explain in full detail on a separate sheet.

Signed _____ Date _____

Telephone (work) _____ (home) _____