EMORY UNIVERSITY SCHOOL OF MEDICINE | Department of Radiology and Imaging Sciences

Application for Alternate Pathway Program

INSTRUCTIONS

The completed form and all other application materials should be returned to Lisa A Walker at Lisa.Smalling@emory.edu.

Application date_____ Date you wish to begin training _____

Full name _____

Date of birth _____

Citizenship _____

Business address _____Phone_____

Home address _____ Phone_____

PREMEDICAL EDUCATION

College	Address	Date: From-To	Degree

MEDICAL EDUCATION

□ Check here if premed/medical education is combined in a single program.

College	Address	Date: From-To	Degree

POSTGRADUATE TRAINING (Internship, Residency, Fellowship)

Position	Institution	City/State/Country	Date: From-To

SPECIAL TRAINING AND INTERESTS

• Have you had any special training or teaching experience that could contribute to research and educational projects during your training? If so, please describe

_____

_____

_____

_____

FELLOWSHIP PREFERENCES

Please check the fellowship programs in which you are the most interested. We make an effort (but not a guarantee) to match applicants with their preferences. All candidates must complete one year of ACGME-accredited fellowship (designated below).

- □ Abdominal Imaging
- □ Breast Imaging
- □ Cardiothoracic Imaging
- □ Emergency and Trauma Imaging
- □ Musculoskeletal Imaging
- □ Neuroradiology (ACGME)
- □ Nuclear Radiology (ACGME)
- □ Pediatric Radiology (ACGME)
- □ Pediatric Neuroradiology
- □ PET/CT

LICENSING

YES answers to the following questions require a written explanation on a separate sheet (positive responses to questions do not necessarily preclude acceptance).

- Have you ever been involved in a malpractice lawsuit or claim (whether or not you were individually named as a defendant)? □ Yes □ No
- Have you ever been called before any entity for questioning concerning unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment? □ Yes □ No
- If you have been licensed to practice medicine, has any such license, or application for it, ever been denied, revoked, suspended, or restricted? □ Yes □ No
- Have you ever been addicted to, or treated for addiction to, a controlled substance, drug, or chemical? □ Yes □ No
- Have you ever used a prescription drug, including controlled substances, for other than therapeutic purposes? □ Yes □ No
- Are you currently suffering from any disability or illness (mental or physical) that could affect your ability to fully practice medicine? □ Yes □ No

• ECFMG status or other qualifications _____

Do you have a current visa? If so, provide details below.

• Visa type _____ Visa number _____ Expiration date _____

REFERENCES

We require <u>three letters of recommendation</u> including a letter from your residency training program, a letter from your current fellowship (if currently enrolled), and at least one letter from other faculty, colleagues, or fellowship directors. These must be emailed directly from letter writers or their assistants to Lisa Walker, addressed to “Emory Radiology Alternate Pathway Program”, and dated within one month of your application date.

I attest that the information included on this application is accurate and correct, to the best of my knowledge.

_____ _____

Signature Date

CLINICAL EXPERIENCE QUESTIONNAIRE

Name: _____

Please rate below your level of clinical experience in the following areas:

CT:

- □ Body (thorax, abdomen and pelvis)
- □ Neuro
- □ Musculoskeletal
- □ Cardiac
- □ CT-guided interventions (i.e. biopsy, drain placement)

MRI:

- □ Body (thorax, abdomen and pelvis)
- □ Neuro
- □ Musculoskeletal
- □ Cardiac

Ultrasound:

- □ Body
- □ Obstetric
- □ Pediatric
- □ US-guided interventions (i.e. thoracentesis, biopsy)

Fluoroscopy:

- □ Body
- □ Pediatric
- □ Fluoroscopy-guided interventions (i.e. lumbar puncture)