

**Duke Cardiovascular Magnetic Resonance Center
Fellowship Program Application**
Duke University Medical Center
Box 3934
Durham, NC 27710

***Please Type or Print in Black ink – Blue does not photocopy well.

Date of Fellowship you are applying for: July 1, 20_____.

DEMOGRAPHIC:

Name:		
Social Security Number:		Date of Birth:
Home Address:		
City:	State:	Zip:
Home Phone:		Country:
Work Address:		
City:	State:	Zip:
Work Phone:		Country:
Fax#:		
Email Address:		
To which Fellowship Program are you applying? (Both programs require a 2 year commitment.)		
Advanced Clinical and Research Track for Physicians		
Post Doctoral Research Track		

REFERENCES:

Please request two letters of recommendation supporting your application and have them mailed to the address at the end of the application. One should be from your supervisor in your current clinical training program or Ph.D. advisor. The other letter should be from a physician or scientist familiar with your previous research. Please list below the physicians whom you have asked to write these letters:		
Name:		Institution:
Address:		Phone:
Name:		Institution:
Address:		Phone:

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EDUCATION and TRAINING

Undergraduate college:
Dates:
Degree:
Undergraduate college (if more than one):
Dates:
Degree:
Graduate or Medical School:
Dates:
Degree:
Graduate or Medical School (if more than one):
Dates:
Degree:
Post Doc or Other Graduate Education
Dates:
Degree if applicable:

Track 1 Applicants Only: INSTITUTION and DEPARTMENT of POST-MD TRAINING (account for all time since receiving M.D. degree)	
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Internship (PGY1):	Date completed:
Internship (PGY1):	Date completed:
Residency:	Date completed:
Residency:	Date completed:
Residency:	Date completed:
Fellowship or Special Training:	Date completed:

What are your plans for the academic year July 1, 2004 – June 30, 2005 (if not indicated above)?

If you have specific goals for your fellowship or specific ideas about the type of training you prefer, please describe them on a separate sheet of paper. Label the heading of the page as **Goals**. Your name should be on the top right of the page.

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AWARDS and HONORS:

RESEARCH EXPERIENCE:

Please describe any research experience on a separate sheet(s) of paper. Please include a list of publications with complete journal citation and the names of all authors in the order in which they appear on the manuscript. (You may enclose reprints if you wish, but you are not required to do so.) Label the heading of the page(s) as **Research**. Your name should be on the top right of the page.

BOARD CERTIFICATION: (Physicians only)

List specialties in which you are board certified or board eligible:	
Specialty:	Yr. (Certified/Eligible):
Specialty:	Yr. (Certified/Eligible):
Specialty:	Yr. (Certified/Eligible):

LICENSURE: (Physicians only)

Attach a copy of current medical license.	
Full License NO.:	
Date of Issue:	Expires:
Are you licensed in any other states? YES NO If Yes, list all other states below.	
State:	License #:
State:	License #:
State:	License #:
Do you have a Limited License? YES NO If Yes, list below.	
License #:	Dates Effective:
Hospital:	

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**THIS SECTION IS TO BE COMPLETED BY NON-US CITIZENS.
COMPLETE ALL APPLICABLE PARTS**

ECFMG Number (attach a copy of ECFMG Certificate):		
Date passed VQE:		
Date passed FMGEMS:		
Awaiting notification?		
Date passed USMLE:		
Step 1:	Step 2:	Step 3:
Are you currently in the United States on a Temporary Visa? (i.e. J-1, H-1, F-1)		
YES NO If Yes, list attach a copy of current I-94 showing expiration date and date first entered U. S. and a copy of current IAP-66.		
If not currently in the United States, have you been in the United States on a temporary visa within the past five years? YES NO If Yes, complete dates below.		
Dates: From – To	Type of Visa	Visa Sponsor
Do you hold permanent immigrant status in the United States? YES NO If Yes, attach a copy of green card or approval letter.		

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FUNDING:

Please describe on a separate sheet of paper any known or potential sources of funding for this fellowship training. Label the heading of the page as **Funding**. Your name should be on the top right of the page. (List Grant#, Title, Grant Source (i.e. NIH, AHA, etc.), Grant Contact Information)

ADDITIONAL INFORMATION:

Is your significant other applying for a position at Duke University? YES NO If Yes, list his/her name and department to which he/she is applying.

Name:

Dept:

Will your significant other be seeking employment during the time of your fellowship?

YES NO If Yes, list his/her name and a brief description of his/her education and experience to help us provide information about relevant job opportunities in this area.

Name:

Education:

Background:

SIGNATURE

I certify that all information in this application is true to the best of my knowledge.

Printed Name of Applicant: _____

Signature of Applicant: _____ Date: _____

Return this completed application and all requested attachments to:

US Postal Address:

DCMRC Fellowship Program
Box 3934
DUMC
Durham, NC 27710

Express Mail Address:

Duke Cardiovascular Magnetic Resonance Center
Duke University Medical Center
4th Floor, Room 4229
Trent Drive-Orange Zone
Durham, NC 27710

Applications should be postmarked no later than January 15, 2005

DCMRC Fellowship Program Application Checklist

1. Reference letters requested	YES	NO
2. Goals Page Attached	YES	NO
3. Research Page Attached	YES	NO
4. Copy of Medical License Attached	YES	NO
5. Funding Page Attached	YES	NO

(Non-US Citizen applicants only)

1. Copy of ECFMG Certificate (Non-US Citizen applicants)	YES	NO
2. Copy of current I-94 and current IAP-66 Attached	YES	NO
3. Copy of Green Card or Approval Letter Attached	YES	NO