



FOR OFFICE USE ONLY

Date received _____

Ref letters: 1. _____

2. _____

3. _____

Abdominal Imaging Fellowship Training Application

Training to begin (month, year): _____

Full Name: _____

Residency Training Program: _____

Present address: _____

Phone: (mobile) _____ (work) _____

E-mail address: _____

Date of Birth: _____ Birthplace: _____ Citizenship: _____

If non US Citizen, Visa Type (J1, H1, etc.) _____

Permanent Resident _____ Other _____

USMLE Exam _____ Where _____ Date _____ Results _____

(Copies of USMLE to be included)

Undergraduate school: _____

Dates: _____ Degree: _____

Medical school: _____

Dates: _____ Degree: _____

Internship: _____

OTHER CLINICAL, HOUSESTAFF, RESEARCH EXPERIENCE, AWARDS & PUBLICATIONS:
(Please attach Curriculum Vitae)

Please include (3) letters of recommendation from physicians who are familiar with your capabilities. One letter should be from your Program Director and at least one letter from a radiologist in the area in which you seek further postgraduate training.

References:

1)

2)

3)

Additional information or comments relevant to your application:

Applicant's signature

Date

Return one completed copy along with your CV, Personal Statement and USMLE Scores to:

Danielle Kruse, M.D.
C/O Candice Pearce
Duke University Medical Center
Department of Radiology
Box 3808
Durham, NC 27710
Telephone: (919) 684-7218