LOYOLA UNIVESITY MEDICAL CENTER
NEURORADIOLOGY FELLOWSHIP PRELIMINARY INQUIRY

PERSONAL INFORMATION

Last Name _____ First Name _____

Middle Initial _____ Date of Birth _____

Address (Line 1) _____

Address (Line 2) _____

City _____ Country _____

State _____ Zip /Country Code _____

Cell Phone _____ E-mail _____

Home Phone _____ E-mail _____

CITIZENSHIP (If not a U.S. citizen you MUST complete all other fields in this area.. Loyola University Medical Center is only able to accept ECFMG Sponsored J-1 Visas.)

U.S. Citizen ◯ YES

◯ NO

Current VISA _____ Expiration Date _____

EDUCATION (If additional space is needed, attach a separate sheet of paper if needed.)

ENTER DATES (Month/Date/Year)

PreMedical School _____ City/State _____

Degree _____ Year Completed _____

Medical School _____ City/State _____

Degree _____ Year Completed _____

Graduate School _____ City/State _____

Degree _____ Year Completed _____

Residency _____ City/State _____

Certificate _____ Year Completed _____

FOREIGN TRAINED (If foreign trained, attach a copy of your ECFMG Certificate)

Certificate Number _____ Certificate Date _____

USMLE (All fields below must be completed - RESULTS (Passed/Failed/Scheduled and Numeric)
ENTER DATES (Month/Date/Year)

STEP 1 - DATE		RESULTS		RESULTS	
STEP 2 (CK) DATE		RESULTS		RESULTS	
STEP 2 (CS) DATE		RESULTS		RESULTS	
STEP 3 - DATE		RESULTS		RESULTS	

TRAINING (1st Post Graduate Year Transitional/Internship)

Training Hospital _____

Type of Training _____

Program Director _____

Dates of Training _____

OTHER EDUCATION: (Training or Hospital Research list in chronological order, including present position)
ENTER DATES (Month/Date/Year)

Institution Name (1) _____

Type of Training _____

Program Director _____

Starting Date _____ Ending Date _____

Institution Name (2) _____

Type of Training _____

Program Director _____

Starting Date _____ Ending Date _____

Institution Name (3)

Type of Training

Program Director

Starting Date Ending Date

Institution Name (4)

Type of Training

Program Director

Starting Date Ending Date

AMERICAN BOARD OF RADIOLOGY EXAMS - **ENTER DATE (Month/Date/Year)**

Date of Core Examination Examination Outcome

Please return this completed PDF inquiry with a copy of your Curriculum Vitae, Personal Statement, USMLE Transcripts and three letters of recommendation, consent form with passport sized photo affixed and a copy of ECFMG Certificate if applicable.

Signature Date

ALL DOCUMENTS MUST BE RECEIVED IN ORDER TO MOVE FORWARD WITH THE APPLICATION PROCESS

THANK YOU FOR CONSIDERING THE LOYOLA UNIVERSITY MEDICAL CENTER NEURORADIOLOGY FELLOWSHIP PROGRAM