BRIGHAM AND WOMEN'S HOSPITAL

CARDIOVASCULAR MEDICINE & RADIOLOGY

APPLICATION FOR NONINVASIVE CARDIOVASCULAR IMAGING FELLOWSHIP

Training / Experience

☐ COMPLETED OR WILL COMPLETE: CARDIOVASCULAR MEDICINE FELLOWSHIP (ANTICIPATED) COMPLETION DATE: _____

☐ COMPLETED OR WILL COMPLETE: RADIOLOGY RESIDENCY (ANTICIPATED)COMPLETION DATE: _____

☐ OTHER: _____ (ANTICIPATED) COMPLETION DATE: _____

PLEASE INDICATE START DATE OF INTEREST: JULY 1, ☐ 2021 ☐ 2022 ☐ 2023

Personal Information

LAST NAME _____ FIRST NAME _____ MIDDLE I. _____ SUFFIX _____

MALE ☐ FEMALE ☐ SOCIAL SECURITY # _____ DATE OF BIRTH _____

BIRTH CITY, STATE/PROVINCE _____ BIRTH COUNTRY _____

COUNTRY OF CITIZENSHIP _____ US PERMANENT RESIDENT? YES ☐ NO ☐

CURRENT NON-IMMIGRANT VISA STATUS _____

ETHNIC ORIGIN: (OPTIONAL)
☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN OR PACIFIC ISLANDER
☐ BLACK, NOT OF HISPANIC ORIGIN ☐ HISPANIC ☐ WHITE, NOT OF HISPANIC ORIGIN

*See definitions of racial/ethnic classifications on page 3

ADDRESS 1: _____

ADDRESS 2: _____

ADDRESS 3: _____

CITY: _____ STATE: _____ ZIP/POSTAL CODE: _____ COUNTRY: _____

HOME TELEPHONE: _____ HOSPITAL PHONE: _____ BEEPER #: _____

E-MAIL ADDRESS: _____ CELLULAR PHONE: _____

Education (please include complete address)

UNDERGRADUATE:

SCHOOL: _____

ADDRESS: _____

DEGREE: _____ FIELD OF STUDY: _____ DATES OF ATTENDANCE _____

GRADUATE:

SCHOOL: _____

ADDRESS: _____

DEGREE: _____ FIELD OF STUDY: _____ DATES OF ATTENDANCE _____

CONTINUED….

MEDICAL SCHOOL:

SCHOOL: _____

ADDRESS: _____

DEGREE: _____ DATES OF ATTENDANCE _____

Post Graduate Education (please include complete address)

INTERNAL MEDICINE TRAINING:

HOSPITAL: _____

PROGRAM DIRECTOR: _____

ADDRESS: _____

DATES OF ATTENDANCE _____

OTHER TRAINING/EXPERIENCE:

HOSPITAL: _____

PROGRAM DIRECTOR: _____

ADDRESS: _____

DATES OF ATTENDANCE _____

HOSPITAL: _____

PROGRAM DIRECTOR: _____

ADDRESS: _____

DATES OF ATTENDANCE

References: Please list the full name, telephone number and email address of three individuals who will provide letters of recommendation. One letter should be from your current or most recent program director.

NAME: _____

EMAIL ADDRESS: _____ TELEPHONE: _____

NAME: _____

EMAIL ADDRESS: _____ TELEPHONE: _____

NAME: _____

EMAIL ADDRESS: _____ TELEPHONE: _____

Additional Documents:

Please provide the following items in addition to your completed application form:

1. Curriculum vitae
2. Personal Statement
3. Three letters of recommendation (sent directly from authors)
4. USMLE scores (if applicable)
5. Recent Photo

Please send the completed application form and all documents to Courtney Bibbo, M.Sc., at cfbibbo@partners.org and copy Cathy Delaware at cdelaware@partners.org.

*Racial/Ethnic classification as proposed by the National Institutes of Health:
American Indian or Alaskan Native A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition
Asian or Pacific Islander: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes China, India, Japan, Korea, the Philippine Islands and Samoa.
Black, not of Hispanic origin: A person having origins in any of the black racial groups of Africa
Hispanic: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race
White, not of Hispanic Origin: A person having origins in any of the original peoples of Europe or the Middle East