UNIVERSITY OF CALIFORNIA SAN DIEGO, SCHOOL OF MEDICINE
SAN DIEGO, CALIFORNIA 92037

Application for Cardiac Imaging Fellowship Training Program

Please return completed application via email to the email address below.
Anthony N. DeMaria, MD
Director, Cardiac Imaging Fellowship Program
University of California, San Diego
9444 Medical Center Dr, MC 7411
San Diego, CA 92037
c/o mrelaford@health.ucsd.edu

_____ Department: Medicine ___ / Cardiology ___
Last, First Middle
Name
Permanent Mailing Address: _____

Present Mailing Address: _____

Telephone Numbers: Home_____ Hospital_____

Email address: _____

Licensed to practice Medicine in State of: _____ License #: _____

Passed USMLE Part I ___ yes ___ no Part II ___ yes ___ no Part III ___ yes ___ no

If you are a Foreign Medical Graduate, have you passed the:

ECFMG ___ yes ___ no Certificate Date_____ Certificate Number_____

Are you on a Visa? Yes ___ No ___ If yes, what type and when does it expire? _____

Proof of U.S. citizenship or eligibility for U.S. employment will be required upon hire in accordance with regulation established pursuant to the Immigration Reform and Control Act of 1986.

EDUCATION

Premedical/preosteopathic: _____ Dates_____ Degree_____

Other: _____ Dates_____ Degree_____

Medical/Osteopathic: _____ Dates_____ Degree_____

Internship: _____ Dates_____ Degree_____
Hospital Chief of Service

Residencies:

_____ Dates_____ Degree_____
Hospital Chief of Service

_____ Dates_____ Degree_____
Hospital Chief of Service

Fellowships:

_____ Dates_____ Degree_____
Hospital Chief of Service

_____ Dates_____ Degree_____
Hospital Chief of Service

Language skills other than English (list languages and place an X in the appropriate area)

Language: _____	Excellent	Good	Fair
Read	___	___	___
Speak	___	___	___
Understand	___	___	___

Language: _____	Excellent	Good	Fair
Read	___	___	___
Speak	___	___	___
Understand	___	___	___

RACE/ ETHNICITY (optional)

___ American Indian or Alaska Native
___ Asian or Pacific Islander
___ Black or African American
___ Hispanic or Latino
___ White
___ Other
___ Decline to declare

PREVIOUS EMPLOYMENT (Professional and/or Scientific)

Place: _____ Dates_____ Duties_____

Place: _____ Dates_____ Duties_____

Scholastic Societies: _____

Honors and Awards: _____

REFERENCES:

Provide (3) three letters of reference:

1. _____
Name Title Institution

2. _____
Name Title Institution

3. _____
Name Title Institution

PRIVACY NOTIFICATION STATEMENT

The information collected is used to satisfy the educational mission of the University and its legal obligations, including determination of eligibility, assessment and evaluation of professional qualifications.

With the exception of the Affirmative Action data, all information requested is mandatory. If the information is not provided, the application will be deemed incomplete and not considered by the Program. The information you provide will be reviewed by the Departmental Residency selection committee and may be released pursuant to applicable Federal or State law. The privacy of your file will be the responsibility of the Department.

Individuals have the right to review their own record in accordance with the Information Practices Act and University policy. Information on these policies may be obtained from the training Program to which you have applied and where your file is maintained.

I hereby authorize representatives of the School of Medicine to contact any or all of my former employers, educational institutions attended, or other persons or organizations determined to have information relevant to my application for clinical training. I further consent to such persons and organizations releasing relevant information to the School of medicine, notwithstanding that it might otherwise be confidential. I understand that any information obtained by the School of Medicine will be treated as confidential personal information. I hereby certify that I have read and understood all statements and questions on this application and that my responses are true and complete to the best of my knowledge. If employed, I understand that falsification of this record may be considered cause for my termination.

Signature of Applicant **Date**