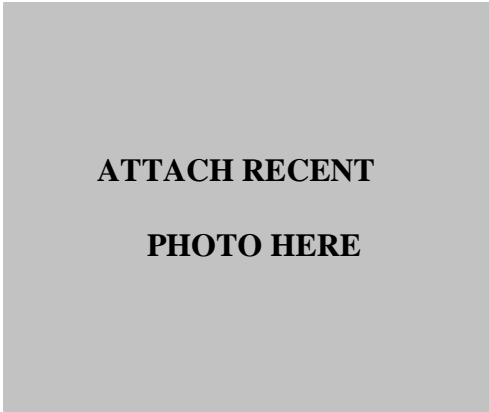


Wake Forest Baptist Health
Wake Forest School of Medicine

Department of Radiology
Medical Center Boulevard
Winston-Salem, North Carolina 27157-1088



Application for Fellowship in:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominal Imaging | <input type="checkbox"/> Musculoskeletal Imaging | <input type="checkbox"/> Neuroradiology |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Breast Imaging | <input type="checkbox"/> Cardiothoracic Imaging |
| <input type="checkbox"/> Interventional Radiology | | <input type="checkbox"/> Pediatric Radiology |

Proposed Beginning Date of Training: Visa Status (if applicable)

Full Name:

Present Address:
Street City/State Postal Code

Telephone:
Daytime Evening Email

Social Security # Citizenship:

Place of Birth: Date of Birth:

Government Obligations (Public Health Services, etc.)

Premedical Education (List Colleges, Degrees and Dates)

Medical School and Dates:

Achievements (Awards, Honorary Societies, etc.):

Post-Doctoral Experience (Internship, Residency, Fellowship, Private Practice and Dates):

Publications:

Professional plans after fellowship program:

Teaching Private practice Generalist Research Specialist

States in which you have a full active medical license:

If you answer yes to any of the following questions, please give full details on a separate sheet.

	Yes	No
1. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been refused membership in a hospital medical staff?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your request for any specific clinical privileges ever been denied or granted with stated limitations?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have your privileges at any institution ever been limited, restricted, or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your narcotics registration ever been suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action, in any medical organization?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been diagnosed with or do you have a medical condition that limits or impairs your ability to practice medicine?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you engaged in the use of any chemical substance(s) that in any way interfered with your abilities to practice medicine?	<input type="checkbox"/>	<input type="checkbox"/>

Name, Address and Telephone Number of Radiology Residency Program Director:

In support of this application, please submit:

- Letter of recommendation from the Director of your Residency Program
- Two additional letters of recommendation

The information contained herein is true to the best of my knowledge and belief.

Signature of Applicant: _____ Date: _____

Enclosures: Curriculum Vitae
Personal Statement

Completed applications should be mailed to the appropriate fellowship director at the address listed below:

Wake Forest School of Medicine
Department of Radiology
Medical Center Boulevard
Winston-Salem, North Carolina 27157-1088

Abdominal Imaging: Scott Carter, M.D.
Breast Imaging: Nadja Lesko, M.D.
Musculoskeletal Radiology: Scott Wuertzer, M.D.
Neuroradiology: Michael Zapadka, M.D.
Nuclear Medicine: Akiva Mintz, M.D.
Pediatric Radiology: Evelyn Anthony, M.D.
Thoracic Imaging: Kerry Link, M.D.

Fellowship Application Form Revised: Sep. 21 2016

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