Cleveland Clinic
Section of Thoracic Imaging
9500 Euclid Avenue, L10
Cleveland, OH 44195
Phone: 216.636.2500
Fax: 216.636.1392

Application for Fellowship in Thoracic Imaging

Fellowship Start Date _____

PERSONAL INFORMATION

Name _____
Last *First* *Middle* *Maiden (If Applicable)*

Present Address _____ **Home Phone** _____

City/State/Zip/Country _____ **Home Email** _____

Professional Address _____ **Professional Phone** _____

City/State/Zip _____ **Professional Email** _____

Social Security # _____ **NPI #** _____ **Fax #** _____

EDUCATION

Undergraduate _____
Name *Location* *Degree* *Date*

Medical School _____
Name *Location* *Degree* *Date*

Internship _____
Name *Location* *Degree* *Date*

Residency _____
Name *Location* *Degree* *Date*

Residency _____
Name *Location* *Degree* *Date*

Fellowship _____
Name *Location* *Degree* *Date*

Training in Radiology (other than residency and fellowship)

_____
Hospital *Location* *Type* *Date* *Program Director*

BOARD CERTIFICATION (American Board of Radiology or equivalent)

Physics Date _____ Score _____ **Written** Date _____ Score _____

Oral Date _____ Score _____

ADDITIONAL INFORMATION

1. Do you have a military or USPHS commitment? ☐ Yes ☐ No

   If yes: Starting _____ for _____ years in _____ (Branch of service)

2. Do you hold a state medical license? ☐ Yes ☐ No
   List states where you hold permanent licensure – include number and expiration date:

   _____

   _____

   _____

3. Have you ever been denied a medical license or had a license revoked? ☐ Yes ☐ No
   If yes, explain _____

   _____

4. International Medical Graduates Only:
   Are you certified by the E.C.F.M.G.? ☐ Yes ☐ No

   Certification number: _____ Certification valid through date: _____

   Examination Taken and Test Scores

   VQE 1 _____ 2 _____ NBME 1 _____ 2 _____ 3 _____

   FMGEMS 1 _____ 2 _____ USMLE 1 _____ 2 _____ 3 _____

5. Citizen of U.S.? ☐ Yes ☐ No Permanent resident ☐ Yes ☐ No A# _____

   ☐ Exchange Visitor Visa (J-1) ☐ Research ☐ Clinical How Long? _____

   ☐ H1B visa ☐ Research ☐ Clinical How Long? _____

   ☐ Other _____ Exp. date _____

6. References and supporting documents:

   Please ask three physicians (one should be your residency program director) who have supervised you in a clinical setting, to send a letter in support of your application. Copies of the following documents are also required: CV, personal statement, medical school diploma, residency/fellowship certificates, and all USMLE step scores. All of these items can be sent to the email address below.

   International Medical Graduates – In addition to the requirements above, please send a certified copy of your ECFMG certificate and qualifying exam results.

   REFERENCES AND SUPPORTING DOCUMENTS WILL NOT BE RETURNED.

The policy of The Cleveland Clinic is to provide equal opportunity to all of our employees and applicants for employment. Decisions concerning employment transfers and promotions are all made upon the basis of the best-qualified candidate without regard to color, race, relation, national origin, age, sex, handicapped status, ancestry, or status as disabled or Vietnam era veteran.

I certify that the information given or attached is true, accurate, and complete.

Signed _____ Date _____

Please return application, LORs and supporting documents by email to:

Zachary Muetzel, Program Manager, muetzez@ccf.org

Ruchi Yadav, MD
Program Director
9500 Euclid Ave, L10
Cleveland, OH 44195