Johns Hopkins Medical Institution Russell H. Morgan
Department of Radiology and Radiological Science

Breast Imaging Fellowship

Thank you for your interest in The Johns Hopkins Division of Breast Imaging Fellowship Program. Please submit the **enclosed application form**, along with:

- **Personal Statement**
- **3 Letters of Recommendation**
- **CV**
- **USMLE Transcript**
- **Medical School Transcript**
- **Photo**

Please indicate the following:

Name: _____ □ Board Eligible □ Board Certified

Start date desired: _____ (Month/Year)

Please forward application and correspondence to:

Email: BreastimagingFellows@jh.edu

Address: 601 N. Caroline Street, Levi Watkins Jr., M.D.,
Outpatient Center 3231-A, Baltimore, MD 21287

Office: (410) 955-8445

Fellowship Program Contact Information:

Lisa A. Mullen, MD
Breast Imaging Fellowship Director
lmullen1@jhmi.edu

Gillian Turk
Breast Imaging Fellowship Coordinator
gcoelho1@jh.edu

The Johns Hopkins Hospital
600 North Wolfe Street
Baltimore MD 21287

Johns Hopkins Bayview Medical Center
4940 Eastern Avenue
Baltimore MD 21224

The Johns Hopkins University
School of Medicine
720 Rutland Avenue
Baltimore MD 21205

APPLICATION FOR APPOINTMENT TO:

Residency Training Program **OR** **Fellowship:**

For The Johns Hopkins Hospital only:
☐ Categorical beginning PGY-1 (Intern)
☐ Advanced beginning PGY-2 or above (Resident)

☐ Clinical
☐ Research
☐ Clinical and Research

For Johns Hopkins Bayview Medical Center only: **OR**
☐ Straight Medicine Tract
☐ General Internal Medicine Track
☐ Both

☐ Rotator
Parent Institution _____

Location: ☐ The Johns Hopkins Hospital ☐ Johns Hopkins Bayview Medical Center

Department / Division:
Service: _____ To Begin _____
(Date)

Instructions: Complete all sections (please print or type all responses). If a section does not pertain to you, mark as N/A (not applicable). Do not leave any section blank nor make reference to an attached CV.

1. Name: Last First Middle

2. Other Name Used: Last First Middle

3. Social Security Number:

4. Current / Local Address (include street, city, state, and zip):

5. Current / Local Telephone Number:

6. Permanent Address (include street, city, state, and zip):

7. Emergency Contact:

Name	Relationship	Mailing Address	Telephone Number
_____	_____	_____	_____

8. E-mail Address:

Applicant=s Name [printed] _____

9. Citizenship: Are you a citizen of the United States: ☐ Yes ☐ No If no, complete the following:

Citizenship _____ Visa Type _____

Entrance Date into U.S._____ Length of Stay Valid to _____

Do you have INS permission to work? ☐ Yes ☐ No

Do you have INS permission to be involved in direct patient care? ☐ Yes ☐ No

Is your degree of patient care involvement limited by your visa? ☐ Yes ☐ No

10. Current Position or Scientific Activities:

11. College(s) Attended (undergraduate education):

Name(s) of School : _____

Mailing Address : _____

Month/Years Attended : _____ Degree(s) Conferred: _____

(Use continuation sheet, if necessary)

12. Professional Education (medical school) or other doctoral program:

Name(s) of School : _____

Mailing Address : _____

Month/Years Attended : _____ Degree(s) Conferred: _____

(Use continuation sheet, if necessary)

13. For International Medical School Graduates: ECFMG No. _____ Valid to _____
(Provide a copy of your certificate)

14. Internship, Residencies, Other Postdoctoral Training & Fellowship Programs:

* Name(s) of School : _____
  Mailing Address : _____
  Dates Attended (Month/Years): _____ Service or Subject: _____

* Name(s) of School : _____
  Mailing Address : _____
  Dates Attended (Month/Years): _____ Service or Subject: _____

* Name(s) of School : _____
  Mailing Address : _____
  Dates Attended (Month/Years): _____ Service or Subject: _____

(Use continuation sheet, if necessary)

Applicant=s Name [printed] _____

15. National Board of Medical Examiners:
Diploma: □ Yes (attach copy) Date: _____ □ No
Board Scores for NBME: Part I _____ Part II _____
USMLE Scores: Step I _____ Step II _____ Step III _____
Clinical Skills Assessment Test Score: _____

16. Hospital Appointments (other than what is included in your training program): List chronologically, appointments to other hospital staffs showing name of hospital, mailing address of hospital, type of appointment (e.g., Active, Moonlighter, OPD, etc.)

* Name of Hospital: _____
Current Mailing Address: _____
Dates of Appointment : _____ Type of Appointment: _____

* Name of Hospital: _____
Current Mailing Address: _____
Dates of Appointment : _____ Type of Appointment: _____

(Use continuation sheet, if necessary)

17. Teaching Appointments (other than what is included in your training program): List chronologically, any teaching appointments showing name of institution and mailing address of institution.

* Name of Institution: _____
Current Mailing Address: _____
Dates of Appointment : _____ Type of Appointment: _____

* Name of Institution: _____
Current Mailing Address: _____
Dates of Appointment : _____ Type of Appointment: _____

(Use continuation sheet, if necessary)

18. Please explain any gaps in time / interruptions in clinical training and/or appointments since receipt of medical or professional degree. **Any gap of one month or more must be explained.**

(Use continuation sheet, if necessary)

19. Licensure: List any health occupation license or registration ever held, showing state(s), country(ies), number(s), date(s), and status.

Applicant=s Name [printed] _____

20. Member or Fellow of (e.g., AMA, ACS, etc.): List all past or present memberships

21. Awards and Honors Received:

22. Scientific or Clinical Interest:

23. Publications (attach list in lieu of listing here):

24. Languages Spoken:

25. Medical References (for clinical applicants): Names and addresses of four (4) physicians who have worked extensively with you or have been responsible for professional observation of you. Do not list: relatives by blood or marriage; the Chief of Service to which you are applying; persons in current training program with you; nor persons who cannot attest to your current level of clinical competency, technical skill, and medical knowledge.

	Name	Mailing Address	Day-time Telephone
∈	_____	_____	_____
		_____	Fax # _____
		_____	
		_____	
∉	_____	_____	_____
		_____	Fax # _____
		_____	
		_____	
∠	_____	_____	_____
		_____	Fax # _____
		_____	
		_____	
∇	_____	_____	_____
		_____	Fax # _____
		_____	
		_____	

Applicant=s Name [printed] _____

Continuation Page: Use this page to document additional information. Copy as necessary.

Applicant=s Name [printed] _____

Statement of Applicant:

-- I fully understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of appointment to or summary dismissal from, the Hospital Medical Staff and/or The Johns Hopkins University.

-- All information submitted by me in this application is true to the best of my knowledge and belief.

-- I authorize the Hospital and/or the University and their representatives to consult with other hospitals and institutions and their representatives and others, in regard to this application.

-- I release from liability the Hospital and/or University, their representatives and agents for their actions or omissions performed in good faith and without malice in evaluating the application as well as those who provide information to the Hospital and/or University in good faith and without malice, and I consent to the release of such information, including otherwise privileged or confidential information.

-- I consent to the release of information to other hospitals and institutions and persons with a legitimate interest and agree to hold the Hospital and/or the University, their representatives and agents free of liability for their actions performed in good faith as a part of the quality assurance program, the credentialing process, peer review and medical evaluation activities.

-- I understand that the information required herein is continuing in nature and I agree to provide any changes in the information provided; i.e., address, name, certification and dates, licensure, etc. I agree to furnish, upon request, an update on any information provided in this application.

A copy of the Statement of Applicant may be used as original.

Date _____ Signature _____

Printed Name _____

The Johns Hopkins Institutions do not discriminate on the basis of race, color, sex, religion, age, national or ethnic origin, sexual orientation, handicap, veteran status, or any other occupationally irrelevant criteria.

Name _____ Department to which Applying _____

please print

Date Completed _____

Supplemental Biographical Information

The information requested is for statistical purposes only and will not be used during consideration of the application.

1. Date of Birth	2. Place of Birth	3. Gender □ Male □ Female

4. Ethnicity/Race:

(Self-Identification)

A. Ethnicity:

□ Of Hispanic or Latino Origin (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race).

□ Not of Hispanic or Latino origin

B. Race:

□ Black or African American: A person having origins in any of the original groups of Africa.

□ Asian: Includes persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent (e.g., Cambodia, China, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).

□ American Indian or Alaskan native: Includes persons having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.

□ Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

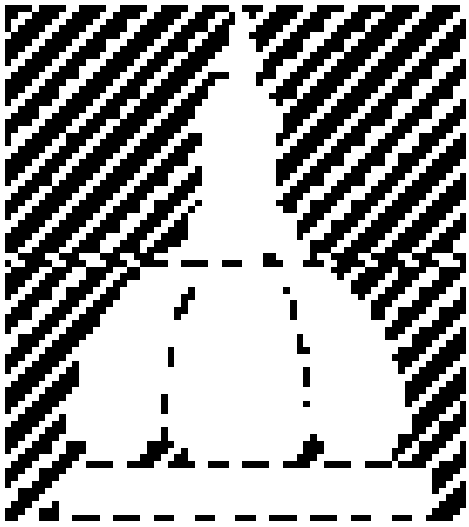
□ White: Includes persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

5. Marital Status:

6. Name of Spouse:

7. Name(s) of Children and Year(s) of Birth:

Johns Hopkins Medicine



Application for
Residency / Fellowship Training Program

as revised: 1/2002

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General Instructions for Completion of this Application

∗ Each section must be **complete** and **legible** or your application will be deemed incomplete and returned to you. This pertains to any attachment you include with the application; e.g., CV, copies of licenses, certifications, etc.

- < The verification process on your education, training, and experience will not begin until a completed application has been received.

- < Do not refer to an enclosed curriculum vitae in lieu of completing a section. A CV does not usually contain all the information needed (e.g., complete dates, addresses, names, etc).

- < If a section does not apply to you, write in AN/A.≅ Do not leave any block blank.

∗ **All chronology must be accounted for from the completion of your medical/ professional degree, to the present.** Gaps of one month or more will cause the verification process to be delayed until you provide an explanation. Delays can also be caused by incomplete names and addresses -- please provide complete information in all sections.

∗ If additional space is needed, attach additional pages (make reference to the question being answered) or, copy the blank application page as often as necessary to provide complete information. Keep these additional pages in sequence with corresponding application pages.