Wake Forest Baptist Health
Wake Forest School of Medicine

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

ATTACH RECENT

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Application for Fellowship in:

☐ Abdominal Imaging
☐ Nuclear Medicine
☐ Interventional Radiology
☐ Musculoskeletal Imaging
☐ Breast Imaging
☐ Neuroradiology
☐ Cardiothoracic Imaging
☐ 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?	☐	☐
2. Have you ever been refused membership in a hospital medical staff?	☐	☐
3. Has your request for any specific clinical privileges ever been denied or granted with stated limitations?	☐	☐
4. Have your privileges at any institution ever been limited, restricted, or revoked?	☐	☐
5. Has your narcotics registration ever been suspended or revoked?	☐	☐
6. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action, in any medical organization?	☐	☐
7. Have you been diagnosed with or do you have a medical condition that limits or impairs your ability to practice medicine?	☐	☐
8. Have you engaged in the use of any chemical substance(s) that in any way interfered with your abilities to practice medicine?	☐	☐

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:

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Abdominal Imaging: James Perumpillichira, M.D.
Breast Imaging: Margaret Yacobozzi, M.D.
Musculoskeletal Radiology: Scott Wuertzer, M.D.
Neuroradiology: Christopher Läck, M.D., Ph.D.
Nuclear Medicine: Shane Masters, M.D., Ph.D.
Thoracic Imaging: Hollins Clark, M.D.