



EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

**Nuclear Medicine &
Molecular Imaging**
Department of Radiology
and Imaging Sciences

NAME _____ **DOB** _____
(First) (Middle) (Last) SSN _____

ADDRESS _____ **BEST CONTACT PHONE#** _____

(City) (State) (Postal Code) **OTHER CONTACT PHONE#** _____

E-MAIL ADDRESS _____

PERMANENT RESIDENT? YES _____ NO _____ **VISA?** YES _____ NO _____

NPI# _____

MEDICAL SCHOOL	LOCATION (City/State)	DATES
_____	_____	_____

ECFMG? YES _____ NO _____ **IF YES, PROVIDE ECFMG #** _____

AWARDS AND HONORS _____

INTERNSHIP SPECIALTY	LOCATION (City/State)	DATES
_____	_____	_____

RESIDENCY TRAINING SPECIALTY	LOCATION (City/State)	DATES
_____	_____	_____

MISDEMEANOR CONVICTION IN THE UNITED STATES? YES _____ NO _____

FELONY CONVICTION IN THE UNITED STATES? YES _____ NO _____

EVER NAMED IN A MALPRACTICE SUIT? YES _____ NO _____

ACLS EXP DATE _____

BLS EXP DATE _____

ADDITIONAL PERTINENT INFORMATION _____

CERTIFICATION: I certify that the information contained within this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position, or if employed, may constitute cause for termination from the program.

APPLICANT'S SIGNATURE

DATE

REQUIREMENTS:

1. *A personal statement describing your career goals and your reason for an interest in our program*
2. *MD Diploma*
3. *Certificate from accredited program*
4. *USMLE I & II, III (if applicable)*
5. *3 Letters of recommendation*
6. *VISA/ECFMG if applicable*
7. *CV*

Please return all materials to:

Ranitta McDowell

Program Coordinator

IR-I, Nuclear Medicine, Nuclear Radiology and VIR

Department of Radiology and Imaging Sciences

p: 404-778-2626 | f: 404-712-7908 e: rsmcdow@emory.edu | w: <http://www.radiology.emory.edu/>