**WE ACCEPT TYPED APPLICATIONS ONLY. HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.**

**INSTRUCTIONS**

The completed form should be returned to Missi Varner (missivarner@wustl.edu)

Recent Photograph of Applicant

Should Accompany

Application

Application Date Date you wish to begin training

Full name

Business address Phone

Home address Phone

Date of birth Place of Birth \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Citizenship

Visa Type/Status (if applicable)

Preferred pronouns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **PREMEDICAL EDUCATION**

College Date: From-To \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Location of College \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Academic Degree(s) and Year(s) Obtained \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **MEDICAL EDUCATION**

School Date: From-To \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If foreign medical school graduate, a copy of standard ECFMG certificate is required with application.***

Honors/Awards \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **PGY-1 INTERNSHIP**

Hospital Date: From-To \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEE NEXT PAGE**

*The Mallinckrodt Institute of Radiology provides all radiologic services for the Washington University Medical Center, including*

*Barnes-Jewish Hospital and St. Louis Children’s Hospital, as well as several other affiliated facilities.*

1. **RESIDENCY TRAINING**

Specialty Institution Date: From-To \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACGME accredited? YES NO

1. **Special Experience in Radiology (research, government, etc.)**

1. **Research Experience (describe)**

1. **USMLE**

Step 1: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Step 2 CK: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Step 2 CS: Pass/Fail Step 3: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

1. **PERSONAL STATEMENT**

Please include a personal statement with this application. This should be attached as a separate document.

**I. TRANSCRIPT AND LETTERS OF RECOMMENDATION**

***It is the responsibility of the applicant to arrange for the following information to be sent directly to the Manager of Medical Education Programs at Mallinckrodt Institute of Radiology: 1) A letter of recommendation from the Dean’s Office and a transcript of your medical school record, 2) Three letters of recommendation including a letter from your residency training program, a letter from your current fellowship (if attending), and a letter from other preceptors who are familiar with your work. Their names and addresses should be listed below so that additional information can be obtained if needed. Their email address should be an official work address; no personal emails.***

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YES answers to the following questions require a written explanation on a separate sheet (positive responses to questions do not necessarily preclude acceptance).**

|  |  |
| --- | --- |
| Have you ever been involved in a malpractice lawsuit or claim (whether or not you were individually named as a defendant)? | Yes No |
| Have you ever been called before any entity for questioning concerning unprofessional conduct, incompetence, negligence, unsafe practices, or mental or physical impairment? | Yes No |
| If you have been licensed to practice medicine, has any such license, or application for it, ever been denied, revoked, suspended, or restricted? | Yes No |
| Have you ever been addicted to, or treated for addiction to, a controlled substance, drug, or chemical? | Yes No |
| Have you ever used a prescription drug, including controlled substances, for other than therapeutic purposes? | Yes No |
| Are you currently suffering from any disability or illness (mental or physical) that could affect your ability to fully practice medicine? | Yes No |

**Pathway training preference**

Please select a combination to total 4 years of training.

*Although we will strive to accommodate your training preferences, your pathway will ultimately depend on availability of current open positions in each section/division.*

|  |  |  |
| --- | --- | --- |
| 2 years nuclear medicine(accredited) | 3 years nuclear medicine(accredited) | 1 year neuro-radiology(accredited) |
| 1 year pediatric radiology(accredited) | 1 year pediatric radiology (non-accredited)\**\*availability may be limited* | 1 year research in one of these specialties\**\*dependent on visa type* |

**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 residency position, or if employed, may constitute cause for termination from the residency program.

Printed Name

Signature Date

Return completed application to:

Melissia Varner, MBA

Manager of Medical Education Services

Mallinckrodt Institute of Radiology

510 S. Kingshighway Blvd.

St. Louis, MO 63110-1076

missivarner@wustl.edu