Application Checklist

* SBI Universal Application
* Personal Statement
* CV
* USMLE Transcript
* Medical School Transcript
* 3 Letters of Recommendation

**Society of Breast Imaging**

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Professional Photo Here

Breast Imaging Fellowship Application

Name:

Present Address:

Permanent Address:

Email:

Telephone:

Place of Birth:

Date of Birth:

Citizenship:

Permanent Resident:

Visa Status/Expiration:

**Education/Training/Research:** (Please begin in chronological order with baccalaureate education, include internship, residency and any additional applicable training or research. Delete or add rows as necessary.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Institution and Location** | **Dates of Attendance**  **(MM/YYYY-**  **MM/YYYY)** | **Field of Study** | **Degree** |
| **Premedical**  **Education** |  |  |  |  |
| **Medical**  **Education** |  |  |  |  |
| **Internship**  **PGY 1 Training** |  |  |  |  |
| **Radiology Residency** |  |  |  |  |
|  |  |  |  |  |

**United States Medical Licensing Examination (USMLE):**

(Copies must be sent to individual programs)

Step 1:

Step 2:

Step 3:

**Comprehensive Osteopathic Medical Licensing Examination (COMLEX):**

(Copies must be sent to individual programs)

Level 1:

Level 2-CE:

Level 2-PE:

Level 3:

**Educational Commission for Foreign Medical Graduates (ECFMG) Exam:**

(Copies must be sent to individual programs)

Where taken:

Date:

Certificate Number:

**Medical Licensure:**

State and Expiration Date:

**Letters of Recommendation:**

Please list the names and contact information of the THREE preceptors that will be providing a letter of recommendation. One letter must come from your diagnostic radiology residency program director. These letters must be sent directly to the programs from the letter author.

|  |  |  |
| --- | --- | --- |
| **Name** | **Title and Institution** | **Email** |
|  |  |  |
|  |  |  |
|  |  |  |

**Background:**

Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country?

Have you had disciplinary actions taken against you by your medical school, internship or residency program?

Are there any special circumstances that should be considered when reviewing your application?

**Applicant’s Certification:**

I certify all the information I have provided is complete and accurate.

Signature:

Date:

**Mail to:**

**Lea C. Gilliland, MD.**

**Director, Breast Imaging Fellowship Program**

**Breast Imaging Center**

**Winship Cancer Center Institute**

**1365-C Clifton Rd, Suite C1104**

**Atlanta, Ga. 30322**

**404-778-4446 or**

**Email to:**

[**lawrence.cockroft.gilliland@emory.edu**](mailto:lawrence.cockroft.gilliland@emory.edu) **and cc:** [**latoya.handsford@emoryhealthcare.org**](mailto:latoya.handsford@emoryhealthcare.org)