Application Checklist

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

 **Society of Breast Imaging**

Copy and Paste

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** |
|  |  |  |
|  |  |  |
|  |  |  |

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:**

**Anna I. Holbrook, 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:**

**anna.holbrook@emory.edu and cc:** [**latoya.handsford@emoryhealthcare.org**](mailto:latoya.handsford@emoryhealthcare.org)