DEPARTMENT OF
Radiology
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE
AND PUBLIC HEALTH

University of Wisconsin Department of Radiology

APPLICATION FOR GRADUATE MEDICAL EDUCATION

Program _____

Level ____ **Beginning** _____

Name _____
Last First Middle (Former)

Address (present) _____

(permanent) _____

Social Security # _____ Date of Birth: _____

Email Address: _____

EDUCATIONAL EXPERIENCE

	Institution Name & City, State	**Dates Attended From-To (Mo/Yr)**	**Type of Program Degree Received**
Pre-Med			
Medical School			
Internship (1st yr)			
Residency			
Other Experience			

Honors, Publications, etc. _____

_____

National Board Exam Scores: Date / Score

Part I _____/_____
Part II _____/_____
Part III _____/_____

FLEX Exam Date / Score

Part I ____/_____
Part II ____/_____

Graduates of Foreign Medical Schools - Please indicate:

Type of Visa _____
ECFMG Cert. No. _____
FMGEMS Exam Results _____
English Exam Results _____

Medical Licensure (required): Wisconsin # _____; Other State _____

Have there been any claims for medical malpractice made against you or your insurance carrier? _____
If yes, please explain in full detail on a separate sheet.

Signed _____ Date _____

Telephone (work) _____ (home) _____

INSTRUCTIONS: Send three letters of recommendation (mailed separately) including Residency Director in hospital of previous residency training and at least two others. Graduates of foreign medical schools, enclose photocopies of your ECFMG Certificate, and results of the FMGEMS Examination and English Competency Examination, if applicable. For general information, contact the central GME Office (608)263-6602. For information about specific programs, call the following number and ask for the appropriate department (608)263-6400.