APPLICANT NAME:_____

APPLICATION FOR MOLECULAR IMAGING FELLOWSHIP

GME Office: (949) 557 - 0252
Email: GMEOffice@hoag.org

Molecular Imaging Fellowship
Application Coversheet

Academic Year Beginning

	July 1, 2025
	July 1, 2026

NAME		
Last:	First:	Middle:
Email:		
Primary Phone:		
EDUCATIONAL INFORMATION		
Residency Specialty:		
Residency Institution/Country:		
From (mm/yy) to (mm/yy):		
Medical School Name:		
Medical School Country:	Year of Graduation:	

Signature: _____

PLEASE SUBMIT THE FOLLOWING to GMEOffice@hoag.org :

- Application form
- Curriculum Vitae: Please include honors, award, & publications on your curriculum vitae.
- A personal statement describing your:
  - reasons for interest in molecular imaging
  - training expectation
  - practice expectations
- Three (3) letters of reference – one letter must be from your residency Program Director.

Reference	Name & Credentials	Title	Organization Affiliation	Phone	Email
1					
2					
3					

- Copies of:
  - Medical School Diploma
  - USMLE/COMLEX Score Report

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CONTACT INFORMATION		
Full Name:		
Current Address:		
City:	State:	ZIP Code:
Country:		
Home Phone:	Work Phone:	Cell Phone:
Are you legally authorized to work in the United States? No ☐ Yes ☐		
Will now or in the future require sponsorship for employment Visa status? No ☐ Yes ☐		
MILITARY SERVICE		
Do you have any military obligations? No ☐ Yes ☐ *If yes, please answer the questions below.*		
Branch:	Current status:	
Future Obligations (time-commitment):	Dates (if known):	
IF A GRADUATE FROM A FOREIGN MEDICAL SCHOOL, HOW DO YOU QUALIFY (ECFMG CERTIFICATE, ETC.)		
ECFMG#:	ECFMG Issue Date:	
Type of VISA:	VISA#:	
UNDERGRADUATE EDUCATION		
1. College/University Name:	City/State:	Degree:
Dates attended from (mm/yy) to (mm/yy):	Honors	
2. College/University Name:	City/State:	Degree:
Dates attended from (mm/yy) to (mm/yy):	Honors	
GRADUATE EDUCATION (NON-MEDICAL)		
1. College/University Name:	City/State:	
Dates attended from (mm/yy) to (mm/yy):	Degree/Study Area:	
Honors:		
2. College/University Name:	City/State:	
Dates attended from (mm/yy) to (mm/yy):	Degree/Study Area:	
Honors:		
MEDICAL SCHOOL I		
Institution Name:	City/State:	
Dates attended from (mm/yy) to (mm/yy):	Graduation Date:	Degree/Study Area:
Honors:		

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MEDICAL SCHOOL II		
Institution Name:	City/State:	
Dates attended from (mm/yy) to (mm/yy):	Graduation Date:	Degree/Study Area:
Honors:		
PG YEARS-INTERNSHIPS, RESIDENCIES, AND FELLOWSHIPS		
1. Hospital/Institution:	Location: City/State/Country:	
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
2. Hospital/Institution:	Location: City/State/Country:	
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
3. Hospital/Institution:	Location: City/State/Country:	
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
4. Hospital/Institution:	Location: City/State/Country:	
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:
5. Hospital/Institution:	Location: City/State/Country:	
Dates attended from (mm/yy) to (mm/yy):	Specialty:	Program Director:

REQUIRED DATA
1. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked? No ☐ Yes ☐
2. Is your license the subject of a pending action or investigation? No ☐ Yes ☐
3. Have your privileges at any hospital ever been denied, suspended, restricted, revoked, deferred, or reviewed pursuant to disciplinary action or not renewed? No ☐ Yes ☐
4. Have you ever withdrawn your application for privileges at a hospital? No ☐ Yes ☐
5. Has your narcotic registration every been suspended or revoked? No ☐ Yes ☐
6. Have you ever been counseled, censured, or subject to disciplinary action in any medical organization, educational institution, or practice facility? No ☐ Yes ☐
7. Are you currently involved in any litigation involving patient care? No ☐ Yes ☐
8. Have you ever been involved in a medical lawsuit in which there was an adverse settlement, judgement, or sanction? No ☐ Yes ☐
9. Have you ever been reported to the National Practitioner Data Bank? No ☐ Yes ☐
10. Have you every been place on probation by your school or residency program? No ☐ Yes ☐
If the answer to any of the Required Data questions (1-10) is YES, please provide full details on a separate document and submit with your application.

APPLICANT NAME:_____

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PLEASE ACCOUNT FOR ANY GAPS IN YOUR MEDICAL EDUCATION AND TRAINING LASTING GREATEER THAN THREE MONTHS.		
Dates	Activity Name	Location (City/State/Country)
1.		
2.		
3.		
4.		
5.		

EXAM RESULTS

USMLE				COMLEX			MCCQE			FLEX EXAM		
#				#			#			#		
	Date	Score	Percentile Rank		Date	Score		Date	Score		Date	Score
S1				L1			P1			P1		
S2 CK				L2 CE			P2			P2		
S2 CS				L2 PE								
S3				L3								

BOARD CERTIFICATION

Board Name	Year Certified	Expiration Date	Board Name	Year Certified	Expiration Date
1.			2.		

LICENSURE

State	License #	Expiration Date	State	License #	Expiration Date
1.			3.		
2.			4.		

Have you had any suspensions, restrictions, or disciplinary actions? No ☐ Yes ☐

If YES, please describe: