



HARVARD MEDICAL SCHOOL Joint Program in Nuclear Medicine



The Joint Program in Nuclear Medicine sponsors an accredited residency training program in nuclear medicine with the primary goal of providing an opportunity for qualified physicians to gain the knowledge and experience needed to practice nuclear medicine at the highest level. The training program also aims to foster the development of nuclear medicine and the careers of its trainees by providing an environment conducive to obtaining skills needed to assume leadership roles in academic and community hospitals. Exposure to a wide range of clinical applications, interaction with clinical staff and faculty with varied interests and areas of expertise as well as the availability of consolidated basic and applied nuclear medical research resources provide a unique environment which fosters a commitment of excellence on the part of the trainees.

Graduates are expected to be capable of directing a nuclear medicine division, teaching nuclear medicine at the postgraduate level, critically assessing the literature, and actively engaging in research. In short, the program strives to enable its graduates to advance nuclear medicine as well as to advance with nuclear medicine.

Training program goals and objectives are accomplished via a fully integrated program among six institutions including: Brigham and Women's Hospital, Beth Israel Deaconess Medical Center, Children's Hospital, Dana-Farber Cancer Institute, Massachusetts General Hospital, and the VA Boston Health Care System. In order to provide a wide range of clinical material, trainees rotate through a number of these institutions. Those enrolled in the one-year training program will typically rotate through a limited number of sites while those in the two-year program are able to rotate through all six. Provisions are made in select cases for individuals who desire more focused training in specific areas of interest such as pediatric nuclear medicine, oncologic nuclear medicine, PET, or nuclear cardiology.

Trainee competencies are evaluated and educational outcomes are assessed using a number of tools including didactic course examinations, a comprehensive In-Training examination, evaluations completed by faculty from each rotation, procedure logs, and other methods.

Resident-trainees are encouraged as well to participate in formal written evaluations of the training program and faculty.

APPLICATION INSTRUCTIONS-2003/2004

Application for residency training in the Joint Program in Nuclear Medicine (JPNM) is a two-step procedure.

STEP 1.- Candidates will first be considered for enrollment in the nuclear medicine training program based upon review of the information submitted to the Training Program Office in the APPLICATION FORM FOR RESIDENCY IN NUCLEAR MEDICINE. Interviews with successful applicants will be conducted with members of the JPNM Faculty.

STEP 2.- Candidates who are offered enrollment in the training program will then be required to successfully complete the credentialing process of the Brigham and Women's Hospital as institutional sponsor of the nuclear medicine training program.

It should be understood that the credentialing application and procedure are a completely separate process from that described in STEP 1., and in some instances may require applicants to submit similar or the same information to the Credentialing Office as submitted to the JPNM.

All information must be **LEGIBLE, VERIFIABLE and COMPLETE**. A curriculum vitae may not be used or referenced in response to any question. Failure to respond to all questions completely will delay processing and could result in rejection of this application. All applications are reviewed on a continuing basis but it is strongly encouraged that completed application materials are submitted in a timely manner.

APPLICATION CHECKLIST-To be returned with the completed APPLICATION FORM..

- Completed application form (attached)
- Current curriculum vitae
- Evidence of USMLE scores
- 3 letters of professional reference
(May not be addressed "To Whom It May Concern")
- Copy of ECFMG certificate (if applicable)
- Evidence of Board certification and current licenses to practice medicine in the U.S.
- 500 word personal statement briefly describing your background and your interest in pursuing training in Nuclear Medicine

Note: Applicants are encouraged to visit the Partners Healthcare website and to review the House Officers Manual which contains extensive information about conditions of employment, the Trainee Contract and other important policies, procedures, and services at the following URL: <http://www.partners.org/departments/teaching/gme/homdir.htm>

Applicants Name (Print)

Applicants Signature (Date)

MAILING INSTRUCTIONS

Jennifer Duane
Training Program Coordinator
Joint Program in Nuclear Medicine
Children's Hospital
300 Longwood Avenue
Boston, Massachusetts 02115

Phone (617) 355-4004
Fax (617) 264-9536
jennifer.duane@tch.harvard.edu

PRINT APPLICANTS NAME

DATE



**APPLICATION FORM
RESIDENCY IN NUCLEAR MEDICINE-2003/2004**

I. Desired Start Date: _____/_____/_____ **12 Month Training Program**

II. Personal Data **24 Month Training Program**

1. Name in full (no initials):

Last _____
First _____
Middle _____ Suffix (Ex: Jr., III) _____
Other name(s) used in professional practice: _____
U.S. Social Security Number: _____
Date of Birth: Month _____ Day _____ Year _____
Place of Birth: City _____ State _____ Country _____
Country of Citizenship: _____

2. Current Hospital/Group/Practice Name: _____
Hospital/Office Street Address: _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____

3. Current Home Street Address: _____
City/Town: _____ State: _____
Zip Code: _____ Country: _____
Phone: (____) _____ Email: _____

4. Permanent Home Street Address: _____
City/Town: _____ State: _____
Zip Code: _____ Country: _____
Phone: (____) _____ Email: _____
FAX: _____

5. If you are not a citizen of the United States, what kind of visa will you hold while you are here?

Type: _____ Visa No.: _____ Expiration Date: _____

6. If applicable, foreign medical school graduates please indicate below your certification by the Education Council for Foreign Medical Graduates (ECFMG).

Certificate Number: _____ Date of Passing: _____

III. Education: Provide complete mailing address where requested

Pre-Medical education (undergraduate):

College or University: _____ Graduation Date: _____
Dates attended: _____ Degree: _____

Medical education: college or university

College or University: _____ Graduation Date: _____
City and State: _____ Degree: _____

Post-Graduate: college or university

College or University: _____ Graduation Date: _____
City and State: _____ Degree: _____

IV. Training:

Internship(s): please use additional sheets if necessary.

Specialty: _____ **Hospital:** _____
Dates attended (Month/Year): From: _____ To: _____
Street Address: _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____
Contact person: _____

Residency(ies) (most recent first). Please use additional sheets if necessary.

Specialty: _____ **Hospital:** _____
Dates attended (Month/Year): From: _____ To: _____
Street Address: _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____
Contact person: _____

Specialty: _____ **Hospital:** _____
Dates attended (Month/Year): From: _____ To: _____
Street Address: _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____
Contact person: _____

Specialty: _____ **Hospital:** _____
Dates attended (Month/Year): From: _____ To: _____
Street Address: _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____
Contact person: _____

Specialty: _____ **Hospital:** _____
Dates attended (Month/Year): From: _____ To: _____
Street Address: _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____
Contact person: _____

Fellowship(s) (most recent first). List the subspecialty training programs you attended. Please use additional sheets if necessary.

Specialty: _____ **Hospital:** _____
Dates attended (Month/Year): From: _____ To: _____
Street Address: _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____
Contact person: _____

V. Board Certification/ Professional Associations:

Please list all current board certifications that you hold in any jurisdiction, foreign or domestic.

Specialty/sub-specialty Board name: _____
Date Certified: _____

Specialty/sub-specialty Board name: _____
Date Certified: _____

Specialty/sub-specialty Board name: _____
Date Certified: _____

1. Have you ever been examined by any specialty board, but failed to pass?
___ No ___ Yes: If yes, please provide a full explanation on a separate sheet and attach.

2. If not certified, have you applied for a certification examination?
___ No ___ Yes: Board name: _____

If No, do you intend to apply for certification examination?
___ No ___ Yes: Board name: _____

If Yes, have you been accepted to take a certification examination?
___ No ___ Yes: Board name: _____

Oral Exam dates: _____ Written Exam dates: _____

3. Are you planning to or have you applied for a certification examination by a second or third specialty board?
___ No ___ Yes: Board name: _____

VI. Current State Licenses:

Type: _____

Date Licensed: _____

Date Expires: _____

Type: _____

Date Licensed: _____

Date Expires: _____

Type: _____

Date Licensed: _____

Date Expires: _____

VII. Additional Data:

1. Has your professional employment ever been suspended, diminished, revoked or terminated at any hospital or healthcare facility or are any proceedings which may result in any such action currently pending?

Yes No

2. Has your medical staff appointment/privileges ever been limited, suspended, diminished, revoked, refused, terminated, restricted, not renewed, relinquished (whether voluntarily or involuntarily) at any hospital or healthcare facility or are proceedings currently pending which may result in any such action?

Yes No

3. Have you ever withdrawn (or voluntarily relinquished) your application for appointment, reappointment, or privileges or resigned from the medical staff, because a disciplinary action or loss or restriction of clinical privileges was threatened or before a decision about your appointment and/or privileges was rendered by a hospital's or healthcare organization's governing board?

Yes No

4. Have you ever been the subject of disciplinary proceedings at any hospital or healthcare facility?

Yes No

5. Have you ever been investigated for scientific misconduct?

Yes No

6. Have you ever been suspended, sanctioned or restricted from participating in any private, federal or state health insurance program (e.g., Medicare, Medicaid or Blue Cross/Blue Shield)?

Yes No

Professional References:

Three letters of reference are required. One reference must be a physician who has supervised your clinical performance or training. The other two must be from individuals who have worked extensively with you. Please list these references below. Please make note that it is the responsibility of the applicants to arrange for letters of reference. **Letters are to be sent directly by the individual authors to S. Ted Treves, M.D., Director of Residency Training at the following address:**

**S.Ted Treves, M.D, Director of Residency Training
Harvard Medical School
Joint Program in Nuclear Medicine
Division of Nuclear Medicine
Children's Hospital
300 Longwood Ave.
Boston, MA 02115, USA**

For any questions, please contact Jennifer Duane at 617-355-4004, FAX: 617-264-9536

Reference Name: _____

Title: _____

Name of Organization: _____ Department; _____

Street Address _____

City/Town: _____ State: _____ Zip Code: _____

Country: _____ Phone: (____) _____

Reference Name: _____

Title: _____

Name of Organization: _____ Department; _____

Street Address _____

City/Town: _____ State: _____ Zip Code: _____

Country: _____ Phone: (____) _____

Reference Name: _____
Title: _____
Name of Organization: _____ Department; _____
Street Address _____
City/Town: _____ State: _____ Zip Code: _____
Country: _____ Phone: (____) _____

Please sign and date below hereby acknowledging that the above information printed on this application is both accurate and current.

SIGNATURE: _____ **DATE SIGNED:** _____

PRINT NAME: _____