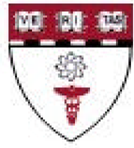
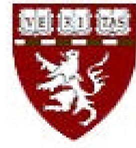




APPLICATION INSTRUCTIONS-2006/2007

Application for residency training in the Joint Program in Nuclear Medicine 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 in the APPLICATION FORM FOR RESIDENCY IN NUCLEAR MEDICINE.

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")
- ☐ If applicable, copy of ECFMG certificate
- ☐ 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 pursing training in Nuclear Medicine
- ☐ For applicants interested in research, 100–150 word statement summarizing interest in and purpose of research

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

________________________ ______________________________

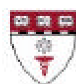
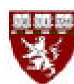
Applicants Name (Print) Applicants Signature (Date)

MAILING INSTRUCTIONS

Jennifer Duane

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

Phone (617) 355-4004
Fax (617) 730-0620
jpnm@childrens.harvard.edu


HARVARD MEDICAL SCHOOL
Joint Program in Nuclear Medicine


APPLICATION FORM
RESIDENCY IN NUCLEAR MEDICINE-2006/2007

I. Desired Start Date: ______/______/______

II. Personal Data

☐ **12 Month Training Program**
☐ **24 Month Training Program**

☐ **Candidates interested in research training check here and attached a 100 – 150 word statement of interest in and purpose of research with the completed application.**

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: ____

*Residency(ies)-**continued***

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 obtain letters of reference. **Please address these letters to S. Ted Treves, M.D., Director of Residency Training and mail to:**

S.Ted Treves, M.D, Director of Residency Training
Harvard Medical School
Joint Program in Nuclear Medicine
Division of Nuclear Medicine
Childre n'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: ____