



HARVARD MEDICAL SCHOOL Joint Program in Nuclear Medicine



Application Instructions

STEP 1: Submit completed *Application Form for Residency in Nuclear Medicine*, with supporting documentation as described in the *Application Checklist*.

STEP 2: Request three letters of reference to be sent directly by the authors to the JPNM Program Director. One reference must be a physician who has supervised your clinical performance or training. The other two references must be from individuals who have worked with you extensively. Letters must be addressed to:

S. Ted Treves, M.D., Program Director
Harvard Medical School Joint Program in Nuclear Medicine
Children's Hospital Boston
300 Longwood Avenue
Boston, MA 02115
USA

STEP 3: Upon receipt of completed application materials and all three letters of reference, applications will be reviewed and select candidates will be invited for in-person interviews with the JPNM Faculty.

STEP 4: Candidates will be notified of their acceptance status in writing.

STEP 5: Candidates who are offered a residency position in the Joint Program in Nuclear Medicine will then be required to successfully complete the application process for a license to practice medicine in the Commonwealth of Massachusetts as well as the credentialing process of Brigham & Women's Hospital, as institutional sponsor of the nuclear medicine training program.

It should be understood that the licensing and credentialing applications and procedures are completely separate processes and are separate from the initial residency application process described in Step 1. In some instances, each process may require applicants to submit similar or the same information to each entity separately.

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 be submitted in a timely manner.

Application Checklist

- ___ Completed *Application Form for Residency in Nuclear Medicine*
- ___ Current curriculum vitae (include months *and* years)
- ___ Evidence of USMLE scores (photocopies of score reports are acceptable)
- ___ Personal Statement (approximately 500 words) briefly describing your background, previous training experiences, and why you wish to pursue residency training in Nuclear Medicine.
- ___ Evidence of Specialty Board Certification and current licenses to practice medicine in the US (if applicable).
- ___ Copy of valid ECFMG Certificate (if applicable).
- ___ For applicants interested in pursuing additional research opportunities, include a statement summarizing interest and purpose of research (100-150 words)
- ___ Three letters of professional reference (to be submitted directly by references)

Mailing Instructions for <u>Application Materials</u>:	Mailing Instructions for <u>Reference Letters</u>:
Jennifer Duane, Training Program Coordinator Joint Program in Nuclear Medicine Children's Hospital Boston 300 Longwood Avenue Boston, MA 02115 Phone: 617-355-4004 Fax: 617-730-0620 jpnm@childrens.harvard.edu	S. Ted Treves, M.D., Program Director Joint Program in Nuclear Medicine Children's Hospital Boston 300 Longwood Avenue Boston, MA 02115

Applicants are strongly encouraged to visit the Partners Healthcare website and review the House Officers Manual at the URL below. This website contains extensive information about conditions of employment, the Trainee Contract and other important policies, procedures and services for trainees employed by Partners Healthcare:

<http://www.partners.org/research/gme/houseofficermanuals/directory.html>



HARVARD MEDICAL SCHOOL
Joint Program in Nuclear Medicine



APPLICATION FORM

RESIDENCY IN NUCLEAR MEDICINE-2007/2008

Desired Start Date:

____/____/____

Select Appropriate Training Pathway:

<input type="checkbox"/>	12 Month Training Program
<input type="checkbox"/>	24 Month Training Program
<input type="checkbox"/>	36 Month Training Program

I. Personal Data

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: Mo ____ Day ____ Yr ____

Place of Birth: City _____ State _____ Country _____

Country of Citizenship: _____

If you are not a citizen of the United States, what type of visa do you intend to obtain?

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

Current Home Street Address: _____

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

Country: _____ Phone: _____ FAX: _____

Email: _____

Permanent Home Street Address: _____

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

Country: _____ Phone: _____ FAX: _____

Email: _____

Current Hospital/Group Practice Name: _____

Hospital/Office Street Address: _____

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

Country: _____ Phone: _____ FAX: _____

II. Education: Provide complete mailing address where requested

Pre-Medical Education (undergraduate):

College or University: _____ Graduation Date: _____

City and State: _____ Country: _____

Dates Attended: _____ Degree: _____

Medical Education: College or university

College or University: _____ Graduation Date: _____

City and State: _____ Country: _____

Dates Attended: _____ Degree: _____

Post-Graduate: College or University

College or University: _____ Graduation Date: _____

City and State: _____ Country: _____

Dates Attended: _____ Degree: _____

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

Certificate Number: _____ Date of Issue: _____

III. Clinical Training

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

Specialty: _____ Hospital: _____

Dates of Training (Month/Year): From: _____ To: _____

Street Address: _____

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

Country: _____ Phone: (____) _____

Contact person: _____ Title: _____

Residencies (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: _____ Title: _____

Residencies -continued

Specialty: _____ **Hospital:** _____

Dates attended (Month/Year): From: _____ To: _____

Street Address: _____

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

Country: _____ Phone: (____) _____

Contact person: _____ Title: _____

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: _____ Title: _____

Specialty: _____ **Hospital:** _____

Dates attended (Month/Year): From: _____ To: _____

Street Address: _____

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

Country: _____ Phone: _____

Contact person: _____ Title: _____

IV. 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

2. If not certified, have you applied for a certification examination?

___ No ___ Yes: Board Name: _____

2a. If No, do you intend to apply for certification examination?

___ No ___ Yes: Board Name: _____

2b. 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: _____

V. Current State Licenses:

State: _____ **Type (full or limited):** _____

Date Licensed: _____ **Date Expires:** _____

State: _____ **Type (full or limited):** _____

Date Licensed: _____ **Date Expires:** _____

State: _____ **Type (full or limited):** _____

Date Licensed: _____ **Date Expires:** _____

VI. 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?

No Yes

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?

No Yes

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?

No Yes

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

No Yes

5. Have you ever been investigated for scientific misconduct?

No Yes

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)?

No Yes

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

SIGNATURE: _____ **DATE SIGNED:** _____

PRINT NAME: _____

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. Note that it is the responsibility of the applicants to obtain letters of reference.

Please ensure letters are *addressed and mailed to*:

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

For any questions, please contact Jennifer Duane at 617-355-4004

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: (____) _____