



**AHMANSON BIOLOGICAL IMAGING CENTER**  
 UCLA SCHOOL OF MEDICINE  
 NUCLEAR MEDICINE DIVISION  
 LOS ANGELES, CA 90095-6942

**APPLICATION FOR NUCLEAR MEDICINE FELLOWSHIP**

I am applying for admission as a fellow in Nuclear Medicine for the period:			to	
<b>I. PERSONAL INFORMATION</b>				
Name:		Last	First	Middle
<input type="checkbox"/> MD	<input type="checkbox"/> PhD	<input type="checkbox"/> DO	<input type="checkbox"/> Other	US Social Security #: _____ Age: _____
Date of Birth:		Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Birthplace:		Country of Citizenship:		
If you are not a citizen of the United States, please specify your VISA status:				
Visa Type:		Sponsor:		Expiration Date: _____
Current Mailing Address:				
Permanent Address:				
<b>II. EDUCATION</b>				
<b>UNDERGRADUATE EDUCATION</b>				
Institution	Location	Dates	Major	Degree
Honors & Awards:				
<b>GRADUATE, PROFESSIONAL, MEDICAL EDUCATION</b>				
Institution	Location	Dates	Major	Degree
Honors & Awards:				

III. CLINICAL TRAINING					
<b>INTERNSHIP</b>					
Hospital	City	State	Specialty	Dates of Training	
<b>ALL SUBSEQUENT RESIDENCIES/FELLOWSHIPS/PRACTICES</b>					
Hospital	City	State	Specialty	Dates of Training	
IV. BOARD CERTIFICATION					
USMLE/National Board Scores:	Step 1:		Step 2:		Step 3:
	Date:		Date:		Date:
V. MEDICAL LICENSURE					
State:		Date Licensed:		Expiration Date:	
State:		Date Licensed:		Expiration Date:	
State:		Date Licensed:		Expiration Date:	
VI. RESEARCH EXPERIENCE					
Field(s) of Research:					
Publications:					
VII. ADDITIONAL INFORMATION					
Extracurricular Activities or Interests:					
Military Experience:	<input type="checkbox"/> Yes (If yes, please complete the following questions) <input type="checkbox"/> No				
	Branch of Service:		Highest Rank:		
	Entry Date:		Discharge Date & Type:		
VIII. REFERENCES					
Please name three references who have supervised your prior clinical training.					
Name:		Title:		Organization:	
Address:				Phone #:	
Name:		Title:		Organization:	
Address:				Phone #:	
Name:		Title:		Organization:	
Address:				Phone #:	

By entering my name and the current date below, I am signifying that all information indicated above is accurate and current, and I hereby acknowledge that any false, misleading or omitted facts on this application may be cause for reprimand or dismissal. I also understand that a California medical license is required in order to begin residency.

Name \_\_\_\_\_

Date \_\_\_\_\_

**The following application materials are required for a complete application file:**

- Completed application form
- Official copy of medical school transcripts
- Copies of all Boards or USMLE certificates
- Three letters of recommendation
- Curriculum Vitae
- Statement of intent stating your interests in Nuclear Medicine and the UCLA program
- For non-US applicants: copy of ECFMG certificate, and visa status (J1 Visa required)

**E-mail and/or send all application materials to:**

Pawan Gupta, MD  
Program Director  
David Geffen School of Medicine  
200MP, Suite B114, MC 957370  
Los Angeles, CA 90095-7370  
pawangupta@mednet.UCLA.edu

Soosan Seyedroodbari  
Proram Coordinator  
sroodbari@mednet.UCLA.edu

For further information, contact Soosan Seyedroodbari at (310)794-1596.