



**Contact Numbers:** Home phone \_\_\_\_\_  
 Work phone \_\_\_\_\_  
 Cell phone \_\_\_\_\_  
 Pager \_\_\_\_\_  
 FAX \_\_\_\_\_  
 Email Address \_\_\_\_\_

**Immigration Status: (check appropriate category):**

\_\_\_\_\_ **U.S. Citizen**

\_\_\_\_\_ **U.S. Permanent Resident**  
                   Country of origin            \_\_\_\_\_  
                   Green Card Number        \_\_\_\_\_  
                   Expiration date            \_\_\_\_\_

\_\_\_\_\_ **U.S. Visa**  
                   Country of origin            \_\_\_\_\_  
                   Visa Category                \_\_\_\_\_  
                   Expiration Date            \_\_\_\_\_

**Education:**

Undergraduate School, City, State	Years Attended	Degree (Year)
Graduate School, City, State	Years Attended	Degree (Year)
Medical School, City, State	Years Attended	Degree (Year)

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<b>Internship (Hospital, City, State)</b>	<b>Year(s)</b>	<b>Specialty</b>
<b>Program Director:</b>		
<b>Residency (Hospital, City, State)</b>	<b>Year(s)</b>	<b>Specialty</b>
<b>Program Director:</b>		
<b>Program Director:</b>		
<b>Prior Fellowship (Hospital, City, State)</b>	<b>Year(s)</b>	<b>Specialty</b>
<b>Program Director:</b>		

**Board Certification Status:**

Examination	Date Passed	Certificate No.	Status, if not passed
USMLE Step 1			
USMLE Step 2			
USMLE Step 3			
ABR - Physics			
ABR - Written			
ABR - Oral			
ECFMG			
Other			

**Licensure**

License Type	Issuing Body (State, Federal)	License #	Expiration Date
<b>Medical</b>			
<b>Medical</b>			
<b>Medical</b>	<b>California**</b>		

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<b>Fluoro permit</b>	<b>California**</b>		
<b>DEA</b>	<b>Federal</b>		
<b>ACLS</b>			
<b>Other</b>			

**\*\*Please note that all California licensures must be current beginning fellowship**

Have you ever been denied a medical license? \_\_\_\_\_

If yes explain why \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**References (three required):**

Name and Title	Mailing Address	Phone email

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

Please mail your signed application with your personal statement and curriculum vitae to the Director of the program for which you are applying. Please have 3 letters of recommendation sent directly from the persons writing them to the Director of Fellowship Program to which you are applying. Thank you.

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**Fellowship Program Directors:**

<b>Program</b>	<b>Director Name (assistant)</b>	<b>Mailing Address</b>	<b>Contact numbers</b>
Body Imaging	Suzanne Palmer, MD (Veronica Ramirez) Email: <a href="mailto:vramirez@usc.edu">vramirez@usc.edu</a>	Department of Radiology UH Second Floor Imaging 1500 San Pablo Street, Los Angeles, CA 90033	Telephone: (323) 442-8721 Fax: (323) 442-8755
Musculoskeletal	Eric White, MD (Nancy Estrada) Email: <a href="mailto:nestrada@usc.edu">nestrada@usc.edu</a>	LAC+USC Medical Center, Diagnostic & Treatment Tower, 1200 North State St., 3 <sup>rd</sup> Floor, Room 3D321, Los Angeles, CA 90033	Telephone: (323) 226-7263 Fax: (323) 226-2280
Nuclear Medicine	Patrick Colletti, MD (Amy Lloyd) Email: <a href="mailto:alloyd@usc.edu">alloyd@usc.edu</a>	LAC+USC Medical Center, Diagnostic & Treatment Tower, 1200 North State St., 3 <sup>rd</sup> Floor, Room 3D321, Los Angeles, CA 90033	Telephone: (323) 409-7677 Fax: (323) 441-8233
PET	Peter Conti, MD (Juanita Evans) Email: <a href="mailto:juanitae@usc.edu">juanitae@usc.edu</a>	Healthcare Consultation I 1510 San Pablo Street, Suite 350 Los Angeles, CA 90033	Telephone: (323) 442-7672 Fax:
Neuroradiology	Meng Law, MD (Amy Lloyd) Email: <a href="mailto:alloyd@usc.edu">alloyd@usc.edu</a>	LAC+USC Medical Center, Diagnostic & Treatment Tower, 1200 North State St., 3 <sup>rd</sup> Floor, Room 3D321, Los Angeles, CA 90033	Telephone: (323) 409-7677 Fax: (323) 441-8233

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<b>Vascular / Interventional</b>	<b>Michael Katz, MD (Amy Lloyd)</b> Email: <a href="mailto:alloyd@usc.edu">alloyd@usc.edu</a>	<b>LAC+USC Medical Center, Diagnostic &amp; Treatment Tower, 1200 North State St., 3<sup>rd</sup> Floor, Room 3D321, Los Angeles, CA 90033</b>	<b>Telephone: (323) 409-7677</b> <b>Fax: (323) 441-8233</b>
<b>Women's Imaging</b>	<b>Linda Hovanesian, MD (Alicia Alvarez-McDermott )</b> Email: <a href="mailto:lhovanes@usc.edu">lhovanes@usc.edu</a>	<b>USC Norris Cancer Center 1441 Eastlake Ave. Room #2315 Los Angeles, CA 90033</b>	<b>Telephone: (323) 865-3203</b> <b>Fax: (323) 865-0063</b>

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