

FELLOW APPLICATION

SOCIETY OF INTERVENTIONAL RADIOLOGY

3975 Fair Ridge Drive, Suite 400 North Fairfax, VA 22033 • (703) 691-1805; FAX (703) 691-1855 • Email: membership@SIRweb.org

APPLICATION FOR (Please Check)

- Active Fellow
 Honorary Fellow
 Corresponding Fellow

IMPORTANT NOTICE

Application will not be considered unless all sections are complete and all supporting documentation has been received by the Fellows' Affairs Committee.

PLEASE TYPE OR PRINT

I GENERAL INFORMATION

1. FULL NAME:	2. BIRTH DATE:
LAST FIRST MIDDLE DESIGNATION (MD, DO, OTHER)	MO. DAY YEAR
3. OFFICE ADDRESS:	
HOSPITAL	WORK PHONE WORK FAX
DEPARTMENT	EMAIL
4. HOME ADDRESS:	
STREET	CITY STATE ZIP CODE
5. MAIL TO BE SENT TO? (check one)	
STREET	HOME PHONE HOME FAX
CITY	STATE ZIP CODE
<input type="checkbox"/> OFFICE <input type="checkbox"/> HOME	

II EDUCATION

1. UNDERGRADUATE:	
SCHOOL CITY STATE	GRAD. DATE DEGREE
2. OTHER GRADUATE:	
SCHOOL CITY STATE	GRAD. DATE DEGREE
3. MEDICAL SCHOOL:	
SCHOOL CITY STATE	GRAD. DATE DEGREE

III PROFESSIONAL TRAINING

1. TYPE	
PROGRAM DIRECTOR	FROM TO
HOSPITAL	CITY STATE ZIP CODE

RESIDENCY(IES)

2a. SPECIALTY	
PROGRAM DIRECTOR	FROM TO
HOSPITAL	CITY STATE ZIP CODE
2b. SPECIALTY	
PROGRAM DIRECTOR	FROM TO
HOSPITAL	CITY STATE ZIP CODE

FELLOWSHIP IN VASCULAR & INTERVENTIONAL RADIOLOGY

3a. SPECIALTY

PROGRAM DIRECTOR	FROM	TO	
HOSPITAL	CITY	STATE	ZIP CODE

3b. PERCENT OF TIME SPENT: PERCENT VASCULAR/INTERVENTIONAL : PERCENT OTHER:

IV SPECIALTY BOARD CERTIFICATION/RADIOLOGICAL QUALIFICATIONS

PHOTOCOPY OF BOARD CERTIFICATION **MUST** BE ATTACHED TO THIS APPLICATION.

1.

PRIMARY BOARD CERTIFICATION	NAME OF SPECIALTY BOARD	YEAR OF CERTIFICATION
-----------------------------	-------------------------	-----------------------

2.

SECONDARY BOARD CERTIFICATION	NAME OF SPECIALTY BOARD	YEAR OF CERTIFICATION
-------------------------------	-------------------------	-----------------------

V CERTIFICATE OF ADDED QUALIFICATION (not required for fellowship)

_____ SPECIALTY _____ DATE RECEIVED

VI CURRENT MEDICAL LICENSURE

1.

STATE	LICENSE NUMBER	DATE OF CERTIFICATION
-------	----------------	-----------------------

2.

STATE	LICENSE NUMBER	DATE OF CERTIFICATION
-------	----------------	-----------------------

VII CURRENT AND PAST PRACTICE ACTIVITIES

1.

HOSPITAL	CITY, STATE	TITLE	HRS/W	DATES FROM/TO
HOSPITAL	CITY, STATE	TITLE	HRS/W	DATES FROM/TO
HOSPITAL	CITY, STATE	TITLE	HRS/W	DATES FROM/TO
HOSPITAL	CITY, STATE	TITLE	HRS/W	DATES FROM/TO

2. PERCENT OF TIME SPENT: VASCULAR/INTERVENTIONAL : OTHER:

VIII PROFESSIONAL SOCIETIES

1.

NAME OF SOCIETY	TYPES OF MEMBERSHIP/OFFICE	DATES FROM/TO
NAME OF SOCIETY	TYPES OF MEMBERSHIP/OFFICE	DATES FROM/TO
NAME OF SOCIETY	TYPES OF MEMBERSHIP/OFFICE	DATES FROM/TO

2. MEMBER OF AMA? (check one) YES NO 4. MEMBER OF RSNA? (check one) YES NO

3. MEMBER OF AHA? (check one) YES NO 5. MEMBER OF ACR? (check one) YES NO

IX OTHER QUALIFICATIONS

REMARKS CONCERNING SPECIAL QUALIFICATIONS OR RELEVANT DATA NOT INCLUDED IN ABOVE.

X SPONSORSHIP

FELLOWS ARE NOMINATED FROM THE ACTIVE MEMBERSHIP OF THE SOCIETY AND MUST BE IN GOOD STANDING IN THE SOCIETY FOR AT LEAST THREE YEARS.)

LETTERS OF RECOMMENDATION ARE REQUIRED FROM TWO SIR FELLOWS IN GOOD STANDING (USE ATTACHED FORMS).

NAME OF FELLOW IN GOOD STANDING

YEAR APPLICANT BECAME A MEMBER IN SIR (MINIMUM 3 YEARS):

NAME OF FELLOW IN GOOD STANDING

APPLICANT FULFILLS WHICH OF THE THREE CRITERIA:

- AUTHOR OF AT LEAST EIGHT SIGNIFICANT PAPERS
- HAS BEEN INVOLVED IN SUPERVISION/TRAIING OF RESIDENTS/FELLOW
- CANDIDATE HAS BEEN AN EXCEPTIONAL LEADER

A. SHALL HAVE BEEN FIRST AUTHOR OF AT LEAST EIGHT (8) SIGNIFICANT PAPERS ON VASCULAR AND INTERVENTIONAL RADIOLOGY WHICH WERE PUBLISHED IN REFERRED JOURNALS.

1.	TITLE	JOURNAL	DATE
2.	TITLE	JOURNAL	DATE
3.	TITLE	JOURNAL	DATE
4.	TITLE	JOURNAL	DATE
5.	TITLE	JOURNAL	DATE
6.	TITLE	JOURNAL	DATE
7.	TITLE	JOURNAL	DATE
8.	TITLE	JOURNAL	DATE

B. SHALL HAVE BEEN INVOLVED IN FULL-TIME SUPERVISION AND TRAINING OF RESIDENTS OR FELLOWS IN VASCULAR AND INTERVENTIONAL RADIOLOGY FOR A MINIMUM OF EIGHT (8) YEARS. LETTERS OF VERIFICATION FOR EACH PROGRAM LISTED MUST BE SUPPLIED BY THE HEAD OF THAT DEPARTMENT.

1.	PROGRAM	DEPARTMENT	TITLE/RESPONSIBILITIES	START DATE	END DATE
2.	PROGRAM	DEPARTMENT	TITLE/RESPONSIBILITIES	START DATE	END DATE
3.	PROGRAM	DEPARTMENT	TITLE/RESPONSIBILITIES	START DATE	END DATE
4.	PROGRAM	DEPARTMENT	TITLE/RESPONSIBILITIES	START DATE	END DATE
5.	PROGRAM	DEPARTMENT	TITLE/RESPONSIBILITIES	START DATE	END DATE

C. SHALL HAVE BEEN AN EXCEPTIONAL LEADER FOR THE SOCIETY THROUGH HIS/HER EXCEPTIONAL SERVICE TO VASCULAR AND INTERVENTIONAL RADIOLOGY. (PLEASE DOCUMENT THIS SERVICE BELOW – ALSO HAVE FELLOWS SUPPLY RECOMMENDATIONS ADDRESSING THIS TOPIC.)

MAKE SURE YOU HAVE INCLUDED THE FOLLOWING WITH YOUR MEMBERSHIP FORM:

(Please Check) CURRICULUM VITAE PHOTOCOPY OF YOUR BOARD CERTIFICATE

SIGNATURE OF APPLICANT

DATE

Please mail your completed application and have appropriate sponsorship recommendation letters forwarded to SIR.