UCDAVIS HEALTH | SCHOOL OF MEDICINE

Advanced Cardiac Imaging (ACI) Fellowship Training Program

The ACI fellowship is a 1-year non-ACGME accredited program that accepts one fellow who has successfully completed an ACGME accredited cardiology fellowship. A valid California medical license is required.

Application Instructions

Please complete attached application. Along with the completed application, the following documentation is also required.

- Personal statement
- Three letters of recommendation, one from your current program director
- Copy of ECFMG Certificate (If applicable)
- Certificate of completion of an ACGME accredited cardiovascular fellowship
- Copy of DL or State issued Identification

Application will not be considered if all required documentation not received before cut-off date of January 15. **Mail c**ompleted application along with required documents to: UCD HEALTH-ACI Training Program, 4860 Y Street, Ste. 2820, Sacramento, CA 95817. Application and documents can also be sent by **email** to ctcuellar@ucdavis.edu.

Contact information is listed below, Do not hesitate to contact us directly if you would like additional information about the training program or if you have any questions about the application process. Thank you for choosing the University of California, Davis and look forward to further correspondence with you.

Program Director

Dr. Edris Aman
eman@ucdavis.edu

University of California, Davis
Cardiovascular Medicine
4860 Y Street, Ste. 2820
Sacramento, CA 95817

Fellowship Coordinator

Catherine Cuellar
PH 916-734-5191
ctcuellar@ucdavis.edu

PH: 916-734-3764 (main)
FAX 916-734-8394

UCDAVIS HEALTH
SCHOOL OF MEDICINE
Department of Internal Medicine
Division of Cardiology

ADVANCED CARDIAC IMAGING
UCDH Fellowship Training Program

Ambulatory Care Center
4860 Y Street, Ste. 2820
Sacramento, CA 95817
PH (916) 734-3764
Fax (916) 734-8394

APPLICATION FOR POSTGRADUATE ADVANCED CARDIAC IMAGING FELLOWSHIP

1. Name: _

2. Desired Starting Date: _

3. Address: _____

_____

Phone Number: _

Pager: _

Email Address: _

4. Licensed to practice in the following states:

	State	License number	Valid through (MM/YY)
a.	_____	_____	_____
b.	_____	_____	_____

5. Has your medical license ever been suspended, revoked, or involuntarily terminated? YES ☐ NO ☐

If yes, please explain:

6. Are you board certified? YES ☐ NO ☐

Board Name _

7. E.C.F.M.G. Certification (for graduates of other than U.S. or Canadian medical schools only)

Certificate Number: _____ Expiration date: _____

8. If you are not a citizen of the United States, do you have the legal right to remain and work in the U.S.?

YES ☐ NO ☐ NOT APPLICABLE ☐

Visa Status: Permanent Resident ☐ J-1 ☐

9. Have you ever been named in a malpractice case? YES ☐ NO ☐

If yes, please explain:

10. Is there anything in your past history that would limit your ability to be licensed or to receive hospital privileges? YES ☐ NO ☐

If yes, please explain:

11. Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, please explain:

12. College and Address:

Dates of Attendance:

Degree Obtained:

Date of Graduation:

13. Medical School and Address:

Dates of Attendance:

Degree Obtained:

Date of Graduation:

14. Internship (institution and address):

Date of Attendance:

Specialty:

15. Residency (institution and address):

Dates of attendance:

Specialty:

Date of Graduation:

16. Additional postgraduate training:

Dates of attendance:

Specialty:

Date of Graduation:

17. Private practice of medicine (location and dates), if applicable:

18. Honors and awards received (give details):

19. Research Experience (including publications)

20. Membership in professional societies (You may exclude any societies which would indicate race, religion, sex, marital status, age, color, national origin or physical handicap)

21. Why do you want to go into the field of advanced cardiac imaging?

22. How important do you perceive research training to be in terms of your career objectives?

23. What would you like to do immediately after your fellowship training period?

CHARACTER REFERENCES (from whom letters of recommendation (LOR) may be expected):

LORs from 2 supervising faculty members and current program director only

24. Name: _ Institution:

Position or Title: _____ Address: _____

Phone Number: _____

Number of Years Known to Applicant: _____

25. Name: _ Institution: _

Position or Title: Address: _

Phone Number: _____ _____

Number of Years Known to Applicant: _____

26. Name: _ Institution: _

Position or Title: Address: _

Phone Number: _____

Number of Years Known to Applicant:

LIST OF REQUIRED ATTACHMENTS:

A) Completed Application
B) Personal Statement
C) Current Curriculum Vitae
D) Copy of ECFMG Certificate (if applicable)
E) Three letters of recommendation
F) Copy of your current medical license
G) Copy of valid identification card

APPLICANT SIGNATURE

_____ _____

Name Date: