



Cardiovascular Research Foundation

55 EAST 59TH STREET, 6TH FLOOR, NEW YORK, NY 10022



APPLICATION FOR POST-GRADUATE TRAINING (P.G.T.)—INTERVENTIONAL CARDIOLOGY

LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS STREET SUITE/APT

CITY STATE COUNTRY ZIP

DAYTIME TELEPHONE (INCLUDE AREA CODE) CELL PHONE: (INCLUDE AREA CODE)

DATE OF BIRTH month day year PLACE OF BIRTH (CITY/STATE)

SEX (Please circle one):
M F

SOCIAL SECURITY NUMBER MARITAL STATUS (Please circle one): Single Married Divorced # OF DEPENDENTS

U.S. CITIZENSHIP (Please circle one): Yes No COUNTRY OF CITIZENSHIP

PLEASE CIRCLE VISA CATEGORY IF NOT A U.S. CITIZEN: Immigrant Visa (Green Card) Temporary Visa Exchange Visitor (J1) Other (Specify):

HOSPITAL ADDRESS STREET SUITE NUMBER

CITY STATE COUNTRY ZIP

HOSPITAL TELEPHONE (INCLUDE AREA CODE) BEEPER: (INCLUDE AREA CODE)

PRE-MEDICAL EDUCATION (SCHOOL) GRADUATION DATE DEGREE

MEDICAL SCHOOL (ATTACH TRANSCRIPT) GRADUATION DATE DEGREE

ADDRESS STREET

CITY STATE ZIP

INTERNSHIP (HOSPITAL) DATES TYPE

PREVIOUS RESIDENCY #1 (HOSPITAL) DATES TYPE

PREVIOUS RESIDENCY #2 (HOSPITAL) DATES TYPE

FELLOWSHIP TRAINING (HOSPITAL) DATES TYPE

OTHER MEDICAL EXPERIENCE

PLEASE PROVIDE (IF ANY) PERMANENT LICENSE NUMBER(S) STATE(S) YEAR(S) ISSUED

USMLE SCORES STEP 1 STEP 2 STEP 3

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT

APPLICANT SIGNATURE DATE

Attach: 1) a small, unmounted photograph, 2) your curriculum vitae, 3) all diplomas and licenses, 4) USMLE scores or ECFMG certificate (if applicable), and 5) three letters of recommendation including Division Chief, Director of the Catheterization Laboratory, and a senior physician who has supervised your training at your current hospital.