



UNIVERSITY OF CALIFORNIA SAN FRANCISCO
SCHOOL OF MEDICINE

Application for Structural Interventional Fellowship AY 2026-2027

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RETURN COMPLETED APPLICATION TO:

Michael Stover
Fellowship Administrator
(415) 514-7288
michael.stover@ucsf.edu

or

Chester Lee
Fellowship Administrator
(415) 514-7703
chester.lee@ucsf.edu

PLEASE TYPE

Name _____ Gender _____
Last First Middle

Email Address _____ Date of Birth _____

Telephone Numbers: Cell _____ Alternate _____

Work Mailing Address: _____

Home Mailing Address: _____

Licensed to practice in Medicine in State (s) of _____ License No _____ AAMC ID _____

USMLE SCORE:

_____ Part I _____ Part II _____ Part III

Are you a Foreign Medical Graduate? ☐ Yes ☐ No If Yes, do you have a ECFMG certificate? ☐ Yes ☐ No

Certificate Date _____ Certificate Number _____

Will you need VISA Sponsorship for fellowship? ☐ Yes ☐ No If yes, list VISA type: _____

Proof of U.S. citizenship or eligibility for U.S. employment will be required upon hire in accordance with regulation established pursuant to the Immigration Reform and Control Act of 1986.

Is funding from an outside source available? Source and amount of grant _____

EDUCATION

Premedical/preosteopathic _____ Dates _____ Degree _____
Other _____ Dates _____ Degree _____
Medical/Osteopathic _____ Dates _____ Degree _____
Internship _____ Dates _____ Degree _____
Hospital _____ Program Director _____

RESIDENCIES

_____ Dates _____ Degree _____
Hospital _____ Program Director _____
_____ Dates _____ Degree _____
Hospital _____ Program Director _____

FELLOWSHIPS

_____ Dates _____ Degree _____
Hospital _____ Program Director _____
_____ Dates _____ Degree _____
Hospital _____ Program Director _____

LANGUAGE SKILLS OTHER THAN ENGLISH (list languages and place an X in the appropriate area)

Language _____	Excellent	Good	Fair	Language _____	Excellent	Good	Fair
Read	_____	_____	_____	Read	_____	_____	_____
Speak	_____	_____	_____	Speak	_____	_____	_____
Understand	_____	_____	_____	Understand	_____	_____	_____

PREVIOUS EMPLOYMENT (professional or scientifically related)

Place _____ Dates _____
Duties _____

Place _____ Dates _____
Duties _____

Scholastic Societies _____

Honors and Awards _____

CAREER GOALS AND PROFESSIONAL PLANS: (please attach CV)

Describe career goals or professional plans for the future. Why have you chosen a career in echocardiography? What are your clinical and research objectives? What are your plans after completion of fellowship training? (Please use the space below or attach a separate personal statement)

REFERENCES

Provide (3) three letters of reference. Note: Preference is to receive directly from your references.

1.			
	Name	Title	Address
2.			
	Name	Title	Address
3.			
	Name	Title	Address

ETHNIC BACKGROUND: (please check one or more that apply below)

- ☐ American Indian or Alaskan Native
- ☐ Hispanic, Latino or of Spanish Origin
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ Asian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Indian
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian / Hmong
- ☐ Pakistani
- ☐ Taiwanese
- ☐ Vietnamese
- ☐ Other Asian _____
- ☐ Decline to answer

PRIVACY NOTIFICATION STATEMENT

The information collected is used to satisfy the educational mission of the University and its legal obligations, including determination of eligibility, assessment, and evaluation of professional qualifications.

With the exception of the Affirmative Action data, all information requested is mandatory. If the information is not provided, the application will be deemed incomplete and not considered by the Program. The information you provide will be reviewed by the Departmental Residency selection committee and may be released pursuant to applicable Federal or State law. The privacy of your file will be the responsibility of the Department.

Individuals have the right to review their own record in accordance with the information Practices Act and University policy. Information on these policies may be obtained from the training Program to which you have applied and where your file is maintained.

I hereby authorize representatives of the School of Medicine to contact any of all of my former employers, educational institutions attended, or other persons or organizations determined to have information relevant to my application for clinical training. I further consent to such persons and organizations releasing relevant information to the School of Medicine, notwithstanding that it might otherwise be confidential. I understand that any information obtained by the School of Medicine will be treated as confidential personal information. I hereby certify that I have read and understood all statements and questions on this application and that my responses are true and complete to the best of my knowledge. If employed, I understand that falsification of this record may be considered cause for my termination.

Signature of Applicant

Date