

Zena and Michael A. Wiener  
Cardiovascular Institute



Marie-Josée and Henry R. Kravis  
Center for Cardiovascular Health

**APPLICATION INSTRUCTIONS**

**ENDOVASCULAR CARDIOLOGY FELLOWSHIP PROGRAM AT THE MOUNT SINAI MEDICAL CENTER**

**PLEASE SEND ONLY THE FOLLOWING WITH YOUR APPLICATION:**

- 1- Completed Mt. Sinai application form **(do not use any other application form)**.
- 2- Minimum of four (4) letters of reference dated in current year, including one (1) from your program director (maximum of five letters of reference).
- 3- Foreign Medical Graduates should send only **one** copy of your ECFMG Certificate with your application (you must have enough time remaining on your visa to allow you to complete your fellowship)
- 4- CV including bibliography of any publications (abstracts and manuscripts).
- 5- A personal statement no longer than one page in length.

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**Original Letters of Reference are to be mailed to:**

**Prakash Krishnan, MD**

**c/o Maria Directo**

**Interventional Cardiology Fellowship Training Program**

**Mount Sinai Medical Center**

**One Gustave L. Levy Place, Box 1030**

**New York, NY 10029**

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Application should be mailed only to the above address. Thank you for your cooperation and your interest in the Cardiology Fellowship Program at the Mount Sinai Medical Center.



**Internship/Residency**

Name/Location

Date

Service

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**Medical Education**

School

Date

Degree

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**Undergraduate Education**

School

Date

Degree

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**Other Graduate Education**

School

Date

Degree

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**AWARDS/HONORS**

Date received

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**Research Experience** (Please identify laboratory, preceptor and include dates)

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**PLEASE CHECK**

**YES**

**NO**

1. Do you have any impairments (physical or mental), which would interfere with your ability to perform the job for which you are applying?
2. Are you licensed to practice medicine in New York State?  
License # \_\_\_\_\_
3. Are you a diplomat of the Educational Commission for Foreign Medical Graduates ? (Please attach copy)  
ECFMG# \_\_\_\_\_

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Please list those individuals whom you have asked to write letters of recommendation on your behalf (minimum of three).

Name

Title

Institution

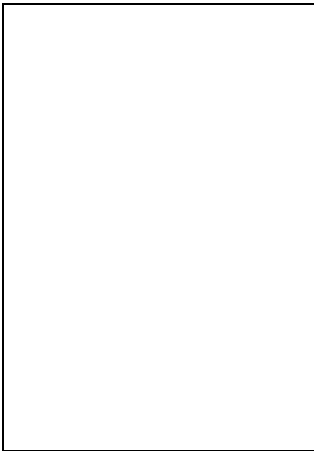
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**Photo Required**

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Signature

**THE MOUNT SINAI HOSPITAL AND THE MOUNT SINAI SCHOOL OF MEDICINE OF THE CITY UNIVERSITY OF NEW YORK ARE EQUAL EMPLOYMENT, AFFIRMATIVE ACTION EMPLOYERS. PERSONNEL ARE CHOSEN ON THE BASIS OF ABILITY AND QUALIFICATIONS WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, MARITAL STATUS, HANDICAP OR VETERAN STATUS IN COMPLIANCE WITH FEDERAL, STATE AND MUNICIPAL LAWS.**