Wake Forest Baptist Medical Center
Department of Radiology
Musculoskeletal Imaging Section
Medical Center Boulevard
Winston-Salem, North Carolina 27157-1088

Supplemental Fellowship Form

Full Name: _____

Date of Birth: _____

States in which you have a full active medical license: _____

		YES	NO
1.	**Has your license to practice medicine in any jurisdiction every been limited, suspended, or revoked?**	☐	☐
2.	**Have you ever been refused membership to a hospital staff?**	☐	☐
3.	**Has your request for any specific clinical privileges ever been denied or granted with stated limitations?**	☐	☐
4.	**Have your privileges at any institution ever been limited, restricted, or revoked?**	☐	☐
5.	**Has your narcotics registration ever been suspended or revoked?**	☐	☐
6.	**Have you ever been denied membership or renewal thereof, or been subject to disciplinary action, in any medical organization?**	☐	☐
7.	**Have you been diagnosed with or do you have a medical condition that limits or impairs your ability to practice medicine?**	☐	☐
8.	**Have you engaged in use of any chemical substance(s) that in any way interfered with your abilities to practice medicine?**	☐	☐