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| *(Photo Optional)* |

**APPLICATION FOR DERMATOPATHOLOGY FELLOWSHIP**

**Commencing July 1, 2021- June 30, 2022**

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| NAME:       DEGREE(s):       MALE FEMALE  HOME ADDRESS:  HOME TELEPHONE #:       MOBILE TELEPHONE #:  EMAIL:  *Phone numbers and email above will be used as primary contact*  CITIZENSHIP:       DATE OF BIRTH: |

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| **VOLUNTARY SELF IDENTIFICATION:** PLEASE SELECT ALL GROUPS THAT YOU CONSIDER YOUR SELF TO BE A MEMBER  HISPANIC OR LATINO  AMERICAN INDIAN/ALASKA NATIVE  ASIAN  AFRICAN AMERICAN OR BLACK  NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  CAUCASIAN OR WHITE  OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PREFER NOT TO ANSWER |

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| **CURRENT INSTITUTION:**  CURRENT INSTITUTION NAME:  CURRENT TITLE:       CURRENT PGY:  BUSINESS ADDRESS:  BUSINESS TELEPHONE #:  EMAIL: |

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| **RESIDENCY TRAINING:**  PROGRAM NAME:  INSTITUTION:  ADDRESS:  DATES ATTENDED:       GRADUATION DATE:       PGY (at graduation):  DERMATOLOGY TRAINED  PATHOLOGY TRAINED |

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| **MEDICAL SCHOOL:**  NAME:  ADDRESS:  DATES ATTENDED:       GRADUATION DATE:       DEGREE:  Approximate final standing in medical school, i.e., upper 10%, middle 1/3:  DEAN’S NAME:  ADDRESS (if different from medical school address):  PRE-MEDICAL COLLEGE NAME:  ADDRESS:  DATES ATTENDED:       GRADUATION DATE:       DEGREE: |

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| **MEDICAL LICENSE INFORMATION:**  TRAINING LICENSE- STATE:       UNRESTRICTED LICENSE (if applicable)- STATE: |

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| ACADEMIC HONORS: |

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| PRESENT MEMBERSHIP IN PROFESSIONAL AND/OR SCIENTIC ORGANIZATIONS: |

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| **HOSPITAL , RESEARCH, & PRACTICAL EXPERIENCE:**  (including dermatology and pathology electives as a medical student, advanced studies, and publications; include details) |

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| FOLLOWING YOUR TRAINING IN DERMATOPATHOLOGY, WHAT ARE YOUR PLANS IN MEDICINE? |

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| OTHER THAN A REGULAR 1 YEAR FELLOWSHIP, ARE YOU INTERESTED IN ADDITIONAL SPECIALIZED TRAINING? IF YES, PLEASE DESCRIBE? |

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| **NATIONAL AND/OR STATE BOARD EXAMINATION:**  (Include date(s) taken and attach a copy of your score report- USMLE and/or ECFMG) |

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| **NAME AND EMAIL ADDRESSES OF THREE REFERENCES:**  (All should submit letters of recommendation directly to us in addition to the Dean’s letter)   1. email: 2. email: 3. email: |

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| DATE:       SIGNATURE:  Please type you name above if you are sending the application electronically |

**REQUIREMENTS**

An application will be considered complete only after the application form, CV, personal statement, three letters of recommendation (sent directly to our program), medical school transcripts, Dean’s letter, and USMLE/ECFMG score reports have been received. Only complete applications will be considered for an interview.

Application will be accepted through: Monday, September 30th, 2019.

The University of Pennsylvania Health System is committed to providing a safe and healthy workplace for its employees, visitors and patients. In order to maintain a healthy work environment, UPHS will no longer hire tobacco users effective July 1, 2013. An applicant will be asked to attest that he/she is currently, and has been, a non-tobacco user for at least six months prior to completing application.

The University of Pennsylvania values diversity and seeks talented students, faculty, and staff from diverse backgrounds. The University of Pennsylvania does not discriminate on the basis or race, sex, sexual orientation, religion, color, national or ethnic origin, age, disability, or status as a Vietnam Veteran or disabled veteran in the administration of educational policies, scholarship and loan awards; athletic or other University administered programs or employment. Questions or complaints regarding this policy should be directed to the Executive Director of the Office of Affirmative Action, 1133 Blockley Hall, Philadelphia, PA 19104-6021 or (215) 898-6993(Voice) or (215) 898-7803 (TDD)