APPLICATION FOR FELLOWSHIP IN DERMATOPATHOLOGY

Program year you wish to apply for: 2020-2022

Please attach photo of yourself

Demographic and Contact Information

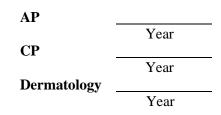
Name:				Da	ate of Birth			
(I	Last)	(First)						
Present Address:				Day Telep	bhone #:			
	Street							
					Evening Telephone #:			
	City	State	Zip					
Email Address:								
Emergency Contac	et:							
		Name		Relationship to you				
Street Address		City		State	Zip	Telephone		
Citizenship:		If not a U.S. citizen, type of visa to be used during stay in USA:						
		(Attach copy	(Attach copy of visa or alien registration)					
Education								
Medical School:								
_		School Name/Location			Degree	Dates		
Residency and Fe	llowship Trainir	g						
Hospital Name/Location		n	Program		Dates			



Boston University School of Medicine

Examinations

Board Eligibility/certification:



References

List three attending physicians who are familiar with your instructing and clinical performance. Each reference listed will need to provide a letter of recommendation.

	Name & Title		Address
1.			
2.			
3.			
4.			
Signature		Date	

Please mail your completed application form along with the following to the address listed below:

- Your current curriculum vitae
- Personal statement
- Minimum of three (3) letters of recommendation
- USMLE scores

Cindy Yee-Lin Manager, Training Programs Dermatopathology Fellowship Training Program Department of Dermatology Boston University School of Medicine 609 Albany Street, J-205, Boston, MA 02118 Email: <u>cinyee@bu.edu</u> Tel: (617) 638-5574