Boston University
School of Medicine

APPLICATION FOR FELLOWSHIP IN DERMATOPATHOLOGY

Please attach photo of yourself

Program year you wish to apply for: 2027-2028

Demographic and Contact Information

Name: _____ Date of Birth _____
(Last) (First)

Present Address: Day Telephone #: _____ Street

_____ Evening Telephone #: _____
City State Zip

Email Address: _____

Emergency Contact: _____
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 of visa or alien registration)

Education

Medical School: _____
School Name/Location Degree Dates

Residency and Fellowship Training

Hospital Name/Location Program Dates

_____

_____

_____

Examinations

Board Eligibility/certification:

			USMLE	Score	Year	Number of Attempts
AP	_____ Year		**Step 1**	_____	_____	_____
CP	_____ Year		**Step 2 CK**	_____	_____	_____
Dermatology	_____ Year		**Step 2 CS**	_____	_____	_____
			Step 3	_____	_____	_____

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 email your completed application form along with the following to dermtrng@bu.edu:

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

Ms. Katie Galek
Manager, Training Programs
Dermatopathology Fellowship Training Program
Department of Dermatology
Boston University School of Medicine
609 Albany Street, J-205, Boston, MA 02118 Email:
dermtrng@bu.edu Tel: (617) 358-9728