DERMATOPATHOLOGY FELLOWSHIP TRAINING PROGRAM APPLICATION

YALE UNIVERSITY SCHOOL OF MEDICINE
15 YORK STREET, LMP 5031
P.O. BOX 208059
NEW HAVEN, CONNECTICUT 06510
(203) 785-6476
FAX: (203) 785-6869

DERMATOPATHOLOGY FELLOWSHIP

BEGINNING JULY ___________________

FULL NAME ____________________________ _______________________________ ________________________________
Last First Middle

TELEPHONE (work) ______________________ (home) (___)___________________________________

(cell) (___)___________________________________

DATE OF BIRTH __________________ PLACE OF BIRTH________________________U.S. CITIZEN? Yes______No________

PRESENT STATUS/POSITION ____ _____________________________________

ADDRESS TO WHICH CORRESPONDENCE SHOULD BE SENT: ____

____

____

MILITARY STATUS (If none, please indicate) ____

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In order to comply with various governmental reporting requirements, we must request that applicants for staff membership provide information concerning their racial/ethnic background. Please check where appropriate (you may elect not to complete this portion):

- o Black, Not of Hispanic Origin
- o Hispanic
- o White, Not of Hispanic Origin
- o Asian or Pacific Islander
- o American Indian/Alaska Native
- o Handicapped
- o Vietnam Veteran
- o I elect not to complete this portion

SIGNATURE OF APPLICANT ______________________________________

DATE ______________________________________

EDUCATION

UNDERGRADUATE ____
School Location

____
Major Degree/Date Graduated

MEDICAL SCHOOL ____
School Location

____
School Degree/Date Graduated

POSTGRADUATE TRAINING

INTERNSHIP ____
Institution Location Specialty Dates

RESIDENCY ____
Institution Location Specialty Dates

OTHER ____
Institution Location Specialty Dates

HONORS AND AWARDS: ____

____

MEMBERSHIP IN SCIENTIFIC/MEDICAL SOCIETIES: ______________________________

____

LICENSURE: ____
State License #

BOARD CERTIFICATION:

____
Medical Specialty Certified or Eligible Date

National Board of Medical Examiners ___________ Yes____________No
If yes, Certificate # ______________________________ Date ______________________________

FLEX Exam ______________________________ ECFMG # ____________________

PREVIOUS AND CURRENT RESEARCH ACTIVITIES (attach reprints or lists of titles of published papers on separate sheet, if necessary):

PERSONAL STATEMENT: Include on one page or less any additional information you feel we should know about you.

REFERENCES: Names and addresses of three people familiar with your clinical ability and scientific and/or professional interests (please have each forward a letter of recommendation directly to the address below).

(1)

(2)

(3)

(4)

Address and forward this application and reference letters to:

Shawn Cowper, M.D.
Director, Dermatopathology Fellowship
Yale Dermatopathology Laboratory
15 York St.
P.O. Box 208059
New Haven, CT 06520-8059