Boston University
School of Medicine

APPLICATION FOR FELLOWSHIP IN DERMATOPATHOLOGY

Please attach photo of yourself

Program year you wish to apply for: 2024-2026

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:

AP _____ Year

CP _____ Year

Dermatology _____ Year

USMLE	Score	Year	Number of Attempts
Step 1	_____	_____	_____
Step 2 CK	_____	_____	_____
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 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**

Ms. Katie Galek
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