



Standardized Application for Pathology Fellowships

Applicant Name		
<i>Last name</i>	<i>First</i>	<i>Middle</i>

Fellowship Type	
This application is being made for a fellowship in (please check one):	
<input type="checkbox"/> Blood banking/Transfusion medicine	<input type="checkbox"/> Breast pathology
<input type="checkbox"/> Chemistry	<input type="checkbox"/> Cytopathology
<input type="checkbox"/> Dermatopathology	<input type="checkbox"/> Diagnostic immunology
<input type="checkbox"/> Forensic pathology	<input type="checkbox"/> Gastrointestinal pathology
<input type="checkbox"/> Genitourinary pathology	<input type="checkbox"/> Gynecologic pathology
<input type="checkbox"/> Hematopathology	<input type="checkbox"/> Medical microbiology
<input type="checkbox"/> Molecular genetic pathology	<input type="checkbox"/> Neuropathology
<input type="checkbox"/> Pathology informatics	<input type="checkbox"/> Pediatric pathology
<input type="checkbox"/> Pulmonary/Mediastinal pathology	<input type="checkbox"/> Renal pathology
<input type="checkbox"/> Soft tissue/Bone pathology	<input type="checkbox"/> Surgical/Oncologic pathology
<input type="checkbox"/> Other, please specify:	

Please affix a recent passport-sized photo here.

If submitting electronically, include a recent passport-style photo in .JPG format with the application.

Training period for which applying:	<i>Start date</i>	<i>Finish date</i>
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Personal Data			
Other names used:			
Present Address			
<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP / Postal code</i>
Permanent Address			
<i>Street</i>	<i>City</i>	<i>State</i>	<i>ZIP / Postal code</i>
Telephone			
<i>Home</i>	<i>Work</i>	<i>Mobile</i>	<i>Fax</i>
E-mail:			

Education				
(Mo/Yr)	(Mo/Yr)	(Undergraduate School)	(Major)	(Degree)
to				
(Mo/Yr)	(Mo/Yr)	(Graduate School, if applicable)		(Degree)
to				
(Mo/Yr)	(Mo/Yr)	(Medical School)		(Degree)
to				
(Mo/Yr)	(Mo/Yr)	(Residency)		(AP, CP, AP/CP, other)
to				
(Mo/Yr)	(Mo/Yr)	(Other GME, if applicable)		Area of training
to				
(Mo/Yr)	(Mo/Yr)	(Other GME, if applicable)		Area of training
to				

Other Experience	
In chronological order, list other educational experiences, jobs, military service or training that is not accounted for above.	
(Mo/Yr)	(Mo/Yr)
to	
(Mo/Yr)	(Mo/Yr)
to	
(Mo/Yr)	(Mo/Yr)
to	

National Boards							
Please indicate national board examination dates and results received.							
USMLE Step 1		USMLE Step 2				USMLE Step 3	
Date passed	Score (optional)	CK - Date passed	Score (optional)	CS - Date passed	Score (optional)	Date passed	Score (optional)
For graduates of international medical schools, are you ECFMG-certified? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list date certified (Mo/Yr):							
COMLEX Level 1		COMLEX Level 2			COMLEX Level 3		
Date passed	Score (optional)	Date passed	Score (optional)	Date passed	Score (optional)	Date passed	Score (optional)

Medical Licensure			
Please list any states in which you hold a license to practice medicine. Please provide a license number. If an application is pending in a state, please write "pending."			
(State)	(Date Issued)	(Medical License Number)	(Active?) <input type="checkbox"/> Yes <input type="checkbox"/> No
(State #2)	(Date Issued)	(Medical License Number)	(Active?) <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been reprimanded, or had your license suspended or revoked in any of these states?		<input type="checkbox"/> Yes (If so, please explain in an attached sheet.) <input type="checkbox"/> No	
Have you ever been named in (and/or had a judgment against you) in a medical malpractice legal suit?		<input type="checkbox"/> Yes (If so, please explain in an attached sheet.) <input type="checkbox"/> No	

Letters of Recommendation and/or References

Please list the individuals who will write your letters of recommendation. At least three are required.

Reference #1

<i>Name</i>		<i>Title</i>	
<i>Institution</i>			
<i>Address</i>	<i>City</i>	<i>State</i>	<i>ZIP / Postal Code</i>
<i>Telephone</i>		<i>Email</i>	

Reference #2

<i>Name</i>		<i>Title</i>	
<i>Institution</i>			
<i>Address</i>	<i>City</i>	<i>State</i>	<i>ZIP / Postal Code</i>
<i>Telephone</i>		<i>Email</i>	

Reference #3

<i>Name</i>		<i>Title</i>	
<i>Institution</i>			
<i>Address</i>	<i>City</i>	<i>State</i>	<i>ZIP / Postal Code</i>
<i>Telephone</i>		<i>Email</i>	

Reference #4 (optional)

<i>Name</i>		<i>Title</i>	
<i>Institution</i>			
<i>Address</i>	<i>City</i>	<i>State</i>	<i>ZIP / Postal Code</i>
<i>Telephone</i>		<i>Email</i>	

Signature (may omit if submitting electronically)

I hereby certify that all of the information on this application is accurate, complete, and current to the best of my knowledge, and that this application is being made for serious consideration of training in the Pathology Fellowship indicated. I understand that accepting more than one fellowship position constitutes a violation of professional ethics and may result in the forfeiture of all positions.

<i>Signature</i>	<i>Date</i>
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