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|  | *College of American Pathologists Residents Forum*  Standardized Application for Pathology Fellowships |

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| Applicant Name | | |
| *Last name/Family Name* | *First* | *Middle* |
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| Fellowship Type | |
| This application is being made for a fellowship in (please check one): | |
| Blood Banking/Transfusion Medicine | Breast Pathology |  |
| Cytopathology | Dermatopathology |
| Gastrointestinal Pathology | Genitourinary Pathology |
| Hematopathology | Medical Microbiology |
| Molecular Genetic Pathology | Neuropathology |
| Pulmonary/Thoracic/Mediastinal Pathology | Renal Pathology |
| Surgical/Oncologic Pathology | Women’s and Perinatal/Gynecologic Pathology |
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| 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.

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| Training period for which applying: | *Start date* | *Finish date* |
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| Personal Data | | | | | | | | | | | |
| Other names used: | |  | | | | | | | | | |
| Present Address | | | | | | | | | | | |
| *Street* | | | | | | *City* | | | *State* | | *ZIP / Postal code* |
|  | | | | | |  | | |  | |  |
| Permanent Address | | | | | | | | | | | |
| *Street* | | | | | | *City* | | | *State* | | *ZIP / Postal code* |
|  | | | | | |  | | |  | |  |
| Telephone | | | | | | | | | | | |
| *Home* | | | *Work* | | | | *Mobile* | | | *Fax* | |
|  | | |  | | | |  | | |  | |
| E-mail: |  | | | | | | | | | | |
| Date of birth:(mm/dd/yyyy) |  | | | | | | Place of birth: |  | | | |
| What race do you self-identify as? | | | | |  | | | | | | |
| Citizenship: |  | | | | | | US Social Security Number: | | | | |
| If not a U.S. citizen, type of Visa: | | | |  | | | | | | | |

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| Education | | | | | |
| *(Mo/Yr)* |  | *(Mo/Yr)* | *(Undergraduate School)* | *(Major)* | *(Degree)* |
|  | **to** |  |  |  |  |
| *(Mo/Yr)* |  | *(Mo/Yr)* | *(Graduate School, if applicable)* |  | *(Degree)* |
|  | **to** |  |  |  |  |
| *(Mo/Dy/Yr)* |  | *(Mo/Dy/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** |  |  | |  |

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| 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** |  |  |

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| 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?***  Yes  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)* | |
|  | |  | | |  | |  | | |  | |  | |
| LMCC | | | | | MCCQE Part I | | | | MCCQE Part II | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | *Date passed* | *Score (optional)* | *Date passed* | *Score (optional)* | *Date passed* | *Score (optional)* | |  |  |  |  |  |  | | | | | | | | | | | | | | |
| 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?)* | | |
|  | | | |  | | |  | | | | Yes  No | | |
| *(State #2)* | | | | *(Date Issued)* | | | *(Medical License Number)* | | | | *(Active?)* | | |
|  | | | |  | | |  | | | | Yes  No | | |
| Have you ever been reprimanded, or had your license suspended or revoked in any of these states? | | | | | | | Yes *(If so, please explain in an attached sheet.)*  No | | | | | | |
| Have you ever been named in (and/or had a judgment against you) in a medical malpractice legal suit? | | | | | | | Yes *(If so, please explain in an attached sheet.)* No | | | | | | |

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| Board Certification | | |
| Please indicate any areas of board certification. | | |
| *Board* | *Area of Certification* | *Date of Certification* |
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| Honors, Awards, Publications, Presentations, Memberships, Leadership/Research Experience | | |
| Please list on attached application forms or include this information in your CV. | | |

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| Letters of Recommendation and/or References | | | | |
| Please list the individuals who will write your letters of recommendation. At least three are required. | | | | |
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| Reference #1 | | | | |
| *Name* | | *Title* | | |
|  | |  | | |
| *Institution* | | | | |
|  | | | | |
| *Address* | *City* | | *State* | *ZIP / Postal Code* |
|  |  | |  |  |
| *Telephone* | | *Email* | | |
|  | |  | | |
| Reference #2 | | | | |
| *Name* | | *Title* | | |
|  | |  | | |
| *Institution* | | | | |
|  | | | | |
| *Address* | *City* | | *State* | *ZIP / Postal Code* |
|  |  | |  |  |
| *Telephone* | | *Email* | | |
|  | |  | | |
| Reference #3 | | | | |
| *Name* | | *Title* | | |
|  | |  | | |
| *Institution* | | | | |
|  | | | | |
| *Address* | *City* | | *State* | *ZIP / Postal Code* |
|  |  | |  |  |
| *Telephone* | | *Email* | | |
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| Reference #4 (optional) | | | | |
| *Name* | | *Title* | | |
|  | |  | | |
| *Institution* | | | | |
|  | | | | |
| *Address* | *City* | | *State* | *ZIP / Postal Code* |
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| *Telephone* | | *Email* | | |
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| 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. | |
| *Signature* | *Date* |
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| Honors and Awards *(if explicitly listed on CV, include highlights here with reference to location on CV)* |
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| Publications and Presentations *(if explicitly listed on CV, include highlights here with reference to location on CV)* |
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| Memberships and Leadership/Research Experience *(if explicitly listed on CV, include highlights here with reference to location on CV)* |
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| Application Packet Check-list (Please provide all documents as one package with documents as separate attachments to the program coordinator.) |
| Completed Standardized Fellowship Application Form with Signature |
| Updated Curriculum Vitae (CV) |
| Included cover letter and/or personal statement (250 words) |
| 3 Letters of Reference (Addressed to the Program Director and e-mailed by the author or their assistant/program coordinator) |
| USMLE’s step 1, 2 CK and 2CS,3. If Canadian, then LMCC, MCCQE Part 1 and MCCQE Part 2. |
| ECFMG Certificate (if applicable) |
| Checked with the fellowship director or coordinator whether there are other items that should be included |
| Included photo |