**THE UNIVERSITY OF CHICAGO**

5841 South Maryland; MC 5067 SECTION Office Phone: (773) 702-0549

Chicago, Illinois 60637-1470 OF DERMATOLOGY Fax: (773) 702-8398

 

**DERMATOPATHOLOGY FELLOWSHIP APPLICATION**

STARTING DATE OF JULY 1, 2025 through JUNE 30, 2026

*Photograph*

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_ Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephones *Business* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Home* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Cell* ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Citizenship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Visa Status (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Place \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Self-Identification – please select one**

🞏 American Indian or Alaska Native 🞏 Hispanic, Latino or of Spanish Origin

🞏 Asian 🞏 White

🞏 Black or African American 🞏 Other

🞏 Hawaiian or Polynesian Native 🞏 No Response

Check appropriate box(es); add year anticipated or fulfilled:

US Board-Eligible in: AP AP/CP Derm Year \_\_\_\_\_\_\_\_\_\_\_\_\_

US Board-Certified in: AP AP/CP Derm Year \_\_\_\_\_\_\_\_\_\_\_\_\_

**References**

*We require 3 reference letters, including one from your current dermatology or pathology program director. Maximum 4 letters. The letters should be addressed to: Dr. Christopher R. Shea, Dermatopathology Program Director, University of Chicago, 5481 S Maryland MC5067, Chicago, IL 60637. Signed original letters should be scanned and attached to an email sent to Mr. Nick Rossi (address below). Direct emails to the program are also accepted.*

1. Name Institution

2. Name Institution

3. Name Institution

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION CHECKLIST**

*Please attach to an email all documents as .pdf files before our deadline of* ***August 24, 2023***

* Application Form
* Curriculum Vitae which includes:
* Education History – all levels including Location, Attendance Dates, Major or Discipline,
* Professional History – including Appointment Title and Location, Dates
* Medical Licensure and Certifications
* Research History – including Research Assignments with Project Name and PI, Location, Start Date, Completion Date
* Professional Appointments and Memberships
* Publications and Presentations
* Honors and Awards
* Personal Statement
* USMLE Score Reports (Steps 1, 2CS, 2CK and 3)
* ECFMG Certificate (if IMG)

Send to:

Dermatopathology Fellowship

Education Coordinator

**dermres1@uchicagomedicine.org**