



P E N N S Y L V A N I A
**Academy of Dermatology
and Dermatologic Surgery**

RESIDENT FELLOW INFORMATION FORM

(Please type or print clearly)

Name: _____

Office Address: _____ Home Address: _____

Office Phone: _____ Home Phone: _____

Fax: _____ Preferred Mailing Address: Office Home

E-Mail: _____ Preferred Communication: Mail E-Mail Fax

Date of Birth: _____ Sex: Male Female

Medical School Graduation Year: _____ Degree Received: _____

Residency Institution: _____

Residency Completion Date (if not completed, please provide anticipated completion date): _____

Fellowship: _____

Fellowship Completion Date (if not completed, please provide anticipated completion date): _____

Primary Specialty: Dermatology Dermatologic Surgery Dermatopathology Other

Board Eligible: Yes No Plan to take Board Examination in: _____

Date of Certification: _____ Practice Start Date: _____

State Licensure(s): _____ Year(s): _____

Dues are free for Resident Fellows who are active full-time in a dermatology residency or fellowship approved by the American Board of Dermatology or the American Board of Osteopathic Dermatology. Resident Fellows have no voting privileges.

Member Signature _____ Date _____

Please mail completed form and curriculum vitae to:

Pennsylvania Academy of Dermatology and Dermatologic Surgery
777 East Park Drive, PO Box 8820
Harrisburg, PA 17105-8820
Questions? Call 866-650-3376.