



## 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.

**Sponsor - Required** (Must be a current active member of PAD)

\_\_\_\_\_  
 Name (print)

\_\_\_\_\_  
 Signature

Applicant 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.