PENNSYLVANIA
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.

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.