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: _____

Preferred Mailing Address: ☐ Office ☐ Home

E-Mail: _____ Preferred Communication: ☐ Mail ☐ E-Mail

Date of Birth: _____

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): _____ Years(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: _____

Mail/Email completed form and curriculum vitae to:

Pennsylvania Academy of Dermatology and Dermatologic Surgery

400 Winding Creek Blvd

Mechanicsburg, PA 17050

info@padermatology.org

Questions? Call: 866-650-3376