



*College of American Pathologists Residents Forum*  
**Standardized Application for Pathology Fellowships**

| Applicant Name |       |        |
|----------------|-------|--------|
| Last name      | First | Middle |

| Fellowship Type                                                        |                                                       |
|------------------------------------------------------------------------|-------------------------------------------------------|
| This application is being made for a fellowship in (please check one): |                                                       |
| <input type="checkbox"/> Blood banking/Transfusion medicine            | <input type="checkbox"/> Breast pathology             |
| <input type="checkbox"/> Chemistry                                     | <input type="checkbox"/> Cytopathology                |
| <input type="checkbox"/> Dermatopathology                              | <input type="checkbox"/> Diagnostic immunology        |
| <input type="checkbox"/> Forensic pathology                            | <input type="checkbox"/> Gastrointestinal pathology   |
| <input type="checkbox"/> Genitourinary pathology                       | <input type="checkbox"/> Gynecologic pathology        |
| <input type="checkbox"/> Hematopathology                               | <input type="checkbox"/> Medical microbiology         |
| <input type="checkbox"/> Molecular genetic pathology                   | <input type="checkbox"/> Neuropathology               |
| <input type="checkbox"/> Pathology informatics                         | <input type="checkbox"/> Pediatric pathology          |
| <input type="checkbox"/> Pulmonary/Mediastinal pathology               | <input type="checkbox"/> Renal pathology              |
| <input type="checkbox"/> Soft tissue/Bone pathology                    | <input type="checkbox"/> Surgical/Oncologic pathology |
| <input type="checkbox"/> Other, please specify:                        |                                                       |

Please affix a recent passport-sized photo here.

If submitting electronically,  
include a recent passport-style  
photo in .JPG format with the  
application.

|                                     |            |             |
|-------------------------------------|------------|-------------|
| Training period for which applying: | Start date | Finish date |
|-------------------------------------|------------|-------------|

| Personal Data          |      |             |                   |
|------------------------|------|-------------|-------------------|
| Other names used:      |      |             |                   |
| Present Address        |      |             |                   |
| Street                 | City | State       | ZIP / Postal code |
| Permanent Address      |      |             |                   |
| Street                 | City | State       | ZIP / Postal code |
| Telephone              |      |             |                   |
| Home                   | Work | Mobile      | Fax               |
| E-mail:                |      |             |                   |
| Citizenship            |      |             |                   |
| Country of citizenship |      | Visa status |                   |



### Education

|         |         |                                  |           |                        |
|---------|---------|----------------------------------|-----------|------------------------|
| (Mo/Yr) | (Mo/Yr) | (Undergraduate School)           | (Major)   | (Degree)               |
| to      |         |                                  |           |                        |
| (Mo/Yr) | (Mo/Yr) | (Graduate School, if applicable) | (Major)   | (Degree)               |
| to      |         |                                  |           |                        |
| (Mo/Yr) | (Mo/Yr) | (Medical School)                 | (Country) | (Degree)               |
| to      |         |                                  |           |                        |
| (Mo/Yr) | (Mo/Yr) | (Residency)                      |           | (AP, CP, AP/CP, other) |
| to      |         |                                  |           |                        |
| (Mo/Yr) | (Mo/Yr) | (Other GME, if applicable)       |           | Area of training       |
| to      |         |                                  |           |                        |
| (Mo/Yr) | (Mo/Yr) | (Other GME, if applicable)       |           | Area of training       |
| to      |         |                                  |           |                        |

### Other Experience

**In chronological order, list other educational experiences, jobs, military service or training that is not accounted for above.**

|         |         |  |
|---------|---------|--|
| (Mo/Yr) | (Mo/Yr) |  |
| to      |         |  |
| (Mo/Yr) | (Mo/Yr) |  |
| to      |         |  |
| (Mo/Yr) | (Mo/Yr) |  |
| to      |         |  |

### National Boards

**Please indicate national board examination dates and results received.**

| USMLE Step 1                                                                                                                                                                                         |                  | USMLE Step 2     |                  |                                             |                  | USMLE Step 3   |                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------|------------------|---------------------------------------------|------------------|----------------|------------------|
| Date passed                                                                                                                                                                                          | Score (optional) | CK - Date passed | Score (optional) | CS - Date passed                            | Score (optional) | Date passed    | Score (optional) |
|                                                                                                                                                                                                      |                  |                  |                  |                                             |                  |                |                  |
| <b>For graduates of international medical schools, are you ECFMG-certified?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide certificate number and date granted.</i> |                  |                  |                  |                                             |                  |                |                  |
| ECFMG Certificate Number                                                                                                                                                                             |                  |                  |                  | Date ECFMG Certificate Granted<br>(MM-YYYY) |                  |                |                  |
|                                                                                                                                                                                                      |                  |                  |                  |                                             |                  |                |                  |
| COMLEX Level 1                                                                                                                                                                                       |                  | COMLEX Level 2   |                  |                                             |                  | COMLEX Level 3 |                  |
| Date passed                                                                                                                                                                                          | Score (optional) | CE - Date passed | Score (optional) | PE - Date passed                            | Score (optional) | Date passed    | Score (optional) |
|                                                                                                                                                                                                      |                  |                  |                  |                                             |                  |                |                  |

### Medical Licensure

**Please list any states in which you hold a license to practice medicine. Please provide a license number. If an application is pending in a state, please write "pending."**

|                                                                                                      |               |                                                                                                           |                                                                       |
|------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| (State)                                                                                              | (Date Issued) | (Medical License Number)                                                                                  | (Active?)<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| (State #2)                                                                                           | (Date Issued) | (Medical License Number)                                                                                  | (Active?)<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever been reprimanded, or had your license suspended or revoked in any of these states?     |               | <input type="checkbox"/> Yes (If so, please explain in an attached sheet.)<br><input type="checkbox"/> No |                                                                       |
| Have you ever been named in (and/or had a judgment against you) in a medical malpractice legal suit? |               | <input type="checkbox"/> Yes (If so, please explain in an attached sheet.)<br><input type="checkbox"/> No |                                                                       |



## Board Certification

Please indicate any areas of board certification.

|       |                       |                       |
|-------|-----------------------|-----------------------|
| Board | Area of Certification | Date of Certification |
|-------|-----------------------|-----------------------|

## Honors, Awards, Publications, Presentations, Memberships, Leadership/Research Experience

Please list on attached application forms or include this information in your CV.

## Letters of Recommendation and/or References

Please list the individuals who will write your letters of recommendation. At least three are required.

### Reference #1

|             |       |       |                   |
|-------------|-------|-------|-------------------|
| Name        | Title |       |                   |
| Institution |       |       |                   |
| Address     | City  | State | ZIP / Postal Code |
| Telephone   | Email |       |                   |

### Reference #2

|             |       |       |                   |
|-------------|-------|-------|-------------------|
| Name        | Title |       |                   |
| Institution |       |       |                   |
| Address     | City  | State | ZIP / Postal Code |
| Telephone   | Email |       |                   |

### Reference #3

|             |       |       |                   |
|-------------|-------|-------|-------------------|
| Name        | Title |       |                   |
| Institution |       |       |                   |
| Address     | City  | State | ZIP / Postal Code |
| Telephone   | Email |       |                   |

### Reference #4 (optional)

|             |       |       |                   |
|-------------|-------|-------|-------------------|
| Name        | Title |       |                   |
| Institution |       |       |                   |
| Address     | City  | State | ZIP / Postal Code |
| Telephone   | Email |       |                   |

## Signature (may omit if submitting electronically)

I hereby certify that all of the information on this application is accurate, complete, and current to the best of my knowledge, and that this application is being made for serious consideration of training in the Pathology Fellowship indicated. I understand that accepting more than one fellowship position constitutes a violation of professional ethics and may result in the forfeiture of all positions.

|           |      |
|-----------|------|
| Signature | Date |
|-----------|------|



**Honors and Awards *(if explicitly listed on CV, include highlights here with reference to location on CV)***



**Publications and Presentations (*if explicitly listed on CV, include highlights here with reference to location on CV*)**



**Memberships and Leadership/Research Experience** *(if explicitly listed on CV, include highlights here with reference to location on CV)*



### Application Packet Check-list

- ✓ Completed Standardized Fellowship Application Form with Signature
- ✓ Updated Curriculum Vitae (CV)
- ✓ Included cover letter and/or personal statement
- ✓ Checked with the fellowship director or coordinator whether there are other items that should be included
- ✓ Included photo

## Supplemental Pathology Application Questionnaire

### Applicant Name

|           |       |        |
|-----------|-------|--------|
| Last name | First | Middle |
|-----------|-------|--------|

Personal Email:

Date of Birth

(mm/dd/yyyy)

Gender:

☐ Male ☐ Female ☐ Decline to state ☐ Other \_\_\_\_\_

Training period for which applying:

Start date

Finish date

### At the time of your start date with UCI will you:

Be a US Citizen: ☐ Yes ☐ No

If no, what is your country of citizenship:

Have a Green Card: ☐ Yes ☐ No ☐ N/A

Require a J1 Visa: ☐ Yes ☐ No ☐ N/A

Use comment box for any additional information:

### Self-Identification (check all that apply)

|                                                                                         |                                                                 |                                                              |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> American Indian or Alaskan Native<br>Tribal affiliation: _____ | <input type="checkbox"/> Black or African American              | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian                                                          | <input type="checkbox"/> African                                | <input type="checkbox"/> Guamanian                           |
| <input type="checkbox"/> Bangladeshi                                                    | <input type="checkbox"/> African American                       | <input type="checkbox"/> Native Hawaiian                     |
| <input type="checkbox"/> Cambodian                                                      | <input type="checkbox"/> Afro-Caribbean                         | <input type="checkbox"/> Other Pacific Islander              |
| <input type="checkbox"/> Chinese                                                        | <input type="checkbox"/> Other Black: _____                     | <input type="checkbox"/> Samoan                              |
| <input type="checkbox"/> Filipino                                                       | <input type="checkbox"/> Hispanic, Latino, or of Spanish Origin | <input type="checkbox"/> No Answer                           |
| <input type="checkbox"/> Indonesian                                                     | <input type="checkbox"/> Argentinean                            | <input type="checkbox"/> White                               |
| <input type="checkbox"/> Japanese                                                       | <input type="checkbox"/> Columbian                              | <input type="checkbox"/> Other, please specify: _____        |
| <input type="checkbox"/> Korean                                                         | <input type="checkbox"/> Cuban                                  |                                                              |
| <input type="checkbox"/> Laotian                                                        | <input type="checkbox"/> Dominican                              |                                                              |
| <input type="checkbox"/> Other Asian _____                                              | <input type="checkbox"/> Mexican/Chicano                        |                                                              |
| <input type="checkbox"/> Pakistani                                                      | <input type="checkbox"/> Other Hispanic                         |                                                              |
| <input type="checkbox"/> Taiwanese                                                      | <input type="checkbox"/> Peruvian                               |                                                              |
| <input type="checkbox"/> Vietnamese                                                     | <input type="checkbox"/> Puerto Rican                           |                                                              |