2019 Dermatopathology Fellowship Applications Instructions

Thank you for your interest in the Harvard Combined Dermatopathology Fellowship Program.

Below are the instructions for submitting an application packet for consideration.

1. All communications and DOCUMENTS should be sent through the dedicated Fellowship email address: HMSdermpathfellowship@bwh.harvard.edu
2. All documents must be in PDF format, please make sure they are in portrait layout and there are no password protections on the forms.
   - Letters of Recommendation should be emailed directly from recommender's office to the dedicated fellowship email in PDF portrait format. See examples below for naming.
3. Documents required for complete applications are:
   - HMS Application, (5 pages & signed by applicant)
   - Curriculum Vitae
   - Personal Statement
   - USMLE scores
   - Letters of Recommendation- THREE
   - *Foreign Medical school- ECFMG Certificate
4. Please name each form with your full name and name of document with Underscore (_) document name LOR_ referee: see examples - Applicant is resident- Peter Brent Brigham and his LOR's are from Drs. Skinner, Bodee, and Lim.

   PeterBrentBrigham_APP
   PeterBrentBrigham_CV
   PeterBrentBrigham_PS
   PeterBrentBrigham_USMLE
   PeterBrentBrigham_LOR_Dr. Skinner
   PeterBrentBrigham_LOR_Dr. Bodee
   PeterBrentBrigham_LOR_Dr. Lim
5. Completed application Deadline: August 15, 2017
6. See attached Fellowship description pages. Instruction page and program description are not returned with application.

Many thanks,
Elaine Garland, Program Coordinator
George F. Murphy, M.D.
Professor of Pathology
Director, Dermatopathology Fellowship
Chief, Program in Dermatopathology
Brigham and Women's Hospital
221 Longwood Avenue - EBRC 401
Boston, MA 02115
hmsdermpathfellowship@bwh.harvard.edu
HARVARD MEDICAL SCHOOL - BWH/BIDMC/MGH

Dermatopathology Fellowship

Description: The Harvard Dermatopathology Program is a fully-approved one year fellowship program that combines the primary resources of the three main Harvard Teaching Hospitals: the Brigham and Women’s Hospital (BWH), the Beth Israel Deaconess Medical Center (BIDMC), and the Massachusetts General Hospital (MGH). Fellows receive comprehensive training in all aspects of dermatopathology and related aspects of precision medicine. Diverse and complementary opportunities in research are abundant.

Requirements: ACGME-accredited residency in Anatomic Pathology, Anatomic and Clinical Pathology, or Dermatology.

Types and Numbers of Appointments: Three (3) Dermatopathology fellowship positions are available.

Facilities: BWH, BIDMC, and MGH provide approximately 3000 beds and 300,000 surgical pathology specimens (of which approximately 75,000 are skin), in addition to consultation cases from affiliated and outside institutions and international specimens through the Partners in Health initiative. The dermatology clinics have a total yearly patient census of over 130,000. Research interests are diverse and include melanoma immunity, cancer epigenetics, stem cell biology, skin biomarkers, graft-versus-host disease, skin regeneration, and immunopathology of face transplantation. The Harvard Medical School and its 500,000-volume collection at the Countway Library are both adjacent to the BWH and BIDMC.

Community: Boston has many universities and cultural facilities. BWH and BIDMC are located in the Longwood Medical area in the immediate environs of the Dana Farber Cancer Center, the Harvard School of Public Health, and the Harvard Dental School, all within several blocks of the Museum of Fine Arts and the Isabella Stewart Gardner Museum. The Massachusetts General Hospital is approximately three miles away, situated at the foot of historic Beacon Hill on the Charles River and in the heart of historic Boston. All amenities of Boston are readily accessible by public transportation.

Stipends: Stipends ranged from $70,000 to $85,313 for PGY years 4-8 for 2017-2018 academic years.

Dermatopathology Staff (complemented by numerous participating clinicians, subspecialists, and investigators):
BWH: George F. Murphy, MD; Fellowship Program Director; Scott R. Granter, MD; John Hanna, MD, PhD; Alvaro Laga, MD; Christine G. Lian, MD; BIDMC: Steven R. Tahan, MD, Institutional Director; Beverly Faulkner-Jones, MD, PhD; Ashley Ward, MD; Mary Jane Zimarowski, MD. MGH: Lyn M. Duncan, MD, Institutional Director; Ruth Foreman, MD, PhD; Mai P. Hoang, MD; Stefan Kraft, MD, PhD; Rosalyn M. Nazarian, MD.

Applications: Applications must be received by August 15, 2017 via EMAIL for appointments beginning on July 01, 2019.
Program Address: Brigham and Women’s Hospital, Harvard Dermatopathology Fellowship, c/o Elaine Garland, Program Coordinator, 221 Longwood Avenue, EBRC 401, Boston, Massachusetts 02115.

Phone: (617) 525-7484 • Fax: (617) 264-5149 • E-mail: hmsdermpathfellowship@bwh.harvard.edu
Please email this application including CV and Personal Statement and USMLE Scores
*ECFMG HMSDermPathFellowship@bwh.harvard.edu (see instructions attached)

Have each of the 3 Letters of Recommendation emailed directly fro LOR office to:
HMSDermPathFellowship@bwh.harvard.edu (see instructions attached)

The deadline for complete application is August 15, 2017

George F. Murphy, M.D.
Director, Dermatopathology Fellowship Program

Applying as:  □ Fellow

Department:____________________________________________________

*Name: __________________________________________________________________________________

Gender: □ M  □ F

Place of Birth_______________________________________ Date of Birth____________________________
City                        State/Country

U.S. Social Security Number___________________________ Citizenship________________ Visa Type ____________

Current Home Address  _____________________________________________________________

Street              City

State                  Zip                  Phone

E-mail address

Professional References: Please provide the names and address of three references who are familiar with your training and experience. The named individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. Examples of professional references are other practitioners in the same field and/or other practitioners in your specialty. None of your references should be relatives or current professional associates. The reference letters must be sent directly from the individuals giving the reference to the above address.

Reference Name: __________________________________________ Title________________________________________

Relationship Role: __________________________ Phone: (    )___________________________

Full Address: ____________________________________________

Reference Name: __________________________________________ Title________________________________________

Relationship Role: __________________________ Phone: (    )___________________________

Full Address: ____________________________________________

Reference Name: __________________________________________ Title________________________________________

Relationship Role: __________________________ Phone: (    )___________________________

Full Address: ____________________________________________
## EDUCATION AND TRAINING

### Education - Undergraduate

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### Medical School

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### Other Graduate Education (MBA, MPH, PHD)

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### Additional Training (If applicable)

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*Program Director / Person to Contact*
SPECIALTIES and CERTIFICATION

☐ NA: Check if this section is NOT APPLICABLE to you.

Primary Specialty: ____________________________________________________________

Board Certified: ☐ Yes ☐ No  Board Name: ________________________________

Date Certified: __________ Date Valid Through: __________ Date Re-certified: __________

Sub-Specialty: ________________________________________________________________

Board Certified: ☐ Yes ☐ No  Board Name: ________________________________

Date Certified: __________ Date Valid Through: __________ Date Re-certified: __________

If you are not currently certified in the specialties listed above, are you currently seeking certification?
☐ Yes  ☐ No

Board Name: ________________________________  Exam date: __________

Board Name: ________________________________  Exam date: __________

PROFESSIONAL WORK HISTORY

☐ NA: Check if this section is NOT APPLICABLE to you.

List chronologically, all professional work history for the past ten (10) years. Please account for all time gaps greater than thirty (30) days on a separate sheet of paper.

Institution / Organization Name: ________________________________________________

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Position: _________________________________________________________________

Reason for discontinuance: _________________________________________________

Institution / Organization Name: ________________________________________________

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Position: _________________________________________________________________

Reason for discontinuance: _________________________________________________
MALPRACTICE / INSURANCE CARRIER

☐ NA: Check if this section is NOT APPLICABLE to you.

Please list all insurance carriers (including insurance companies, hospitals, clinics, employers, etc) which have provided professional liability coverage within the last 10 years, including training. Please list current malpractice carrier first. Please use a separate sheet if necessary.

Current Carrier Name

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Address

City

State

Zip

Policy Number

Amount of coverage ($1mil - $3mil)

Years with current carrier

Previous Carrier Name

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Address

City

State

Zip

Policy Number

Amount of coverage ($1mil - $3mil)

Years with previous carrier

LICENSING

☐ NA: Check if this section is NOT APPLICABLE to you.

List all Professional Licenses, current and past.

Number: __________ State: _______ Expiration Date: __________ Issued: __________ Type: _______ (full, temp)

Number: __________ State: _______ Expiration Date: __________ Issued: __________ Type: _______ (full, temp)

Federal DEA
Certificate Number: ______________________ Expiration Date: __________ Type: _______

Massachusetts Controlled Substance Certificate Number: ______________________ Date Issued: ______________________

Professional Associations: Please list current memberships in Professional Societies, Academies, Colleges

Association Name: ______________________ From: __________ To: __________

Association Name: ______________________ From: __________ To: __________

Other Special Certifications:

Are you certified in CPR? ☐ Yes ☐ No Expiration Date: __________

Classifications: Basic Life Support (BLS) ☐ Exp __________

Advanced Cardiac Life Support (ACLS) ☐ Exp __________

Health Care Provider (Core C) ☐ Exp __________

Advanced Trauma Life Support (ATLS) ☐ Exp __________

Neonatal Advanced Life Support (NALS) ☐ Exp __________

Pediatric Advanced Life Support (PALS) ☐ Exp __________

Other: ______________________ Exp __________
**PROFESSIONAL QUESTIONS**

**Professional Data:** If the answer to questions (a-g) is yes, please give full details on a separate sheet.

| (a) | Has your membership status or privileges at any hospital/facility ever been denied, limited, revoked, suspended, reduced or not renewed? | yes □ | no □ |
| (b) | Have you ever been subjected to disciplinary proceedings relating to your license to practice in any jurisdiction? | yes □ | no □ |
| (c) | Has your license to practice in any jurisdiction ever been limited, suspended or revoked? | yes □ | no □ |
| (d) | Are there any pending/unresolved complaints against your license in MA or in any other state where you hold an active license? | yes □ | no □ |
| (e) | Have you ever been the subject of inquiry or of disciplinary action by any professional society, governmental or other regulatory agency? | yes □ | no □ |
| (f) | Have you ever had any malpractice claims/suits brought against you? | yes □ | no □ |
| (g) | An applicant for appointment with a sealed record on file with the commissioner of probation may answer ‘no record’ with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. In addition, any applicant for appointment may answer ‘no record’ with respect to any inquiry relative to prior arrests, court appearances and adjudication in all cases of delinquency or as a child in need of services which did not result in a criminal conviction. |
| (i.) | Have you ever been convicted of a felony? | yes □ | no □ |
| (ii.) | Have you been convicted of a misdemeanor within the past 5 years? (Do not include a first conviction for drunkenness, simple assault, speeding, minor traffic violations, affray or disturbance of the peace). | yes □ | no □ |

**ATTESTATION:**

*My answers to the questions above are true and complete to the best of my knowledge. I understand that if I misrepresent or withhold information, it may result in my application being disapproved, or I may be terminated, if discovered after my appointment begins. The Brigham and Women’s Hospital (BWH) may make inquiries regarding my history and character to prior employers, etc. and I hereby release employers or individuals from all liability in responding to inquiries in connection with my application and release the BWH from all liability with respect to such inquiries.*

Signature of Applicant __________________________ Date ________________

Printed Name of Applicant __________________________

*(If you use your middle or other name as- Preferred first name) __________________________