The Ronald O. Perelman Department of Dermatology
240 East 38th Street, 11th Floor
New York, NY 10016
Tel (212)-263-5245 / Fax (212)-263-8752

Please respond to the following questions:

Are you a current Dermatology resident in your country? Yes __________ No___________

(If yes, what year of residency training? _____________
Note: only those in their final year of training are eligible to apply)

Are you Dermatology board certified? Yes__________ No___________

(if so, please indicate year of board certification) _______________ What Country?___________________

Desired Month/Start Date:____________________________

Length of Training: **1 Month only** (select one)
General Dermatology ______________ **OR** Hair _______________(Dr Shapiro only)

NAME:

____

Last Name Middle Name First Name

Mailing Address: ____

____

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Present Address:
(if different) ____

____

____

Telephone: ____________________ E-mail: ____________________________

Date of Birth: __________________ Place of Birth: ______________________

Citizenship: _____________________ (Identify Country)

Emergency Contact: _____________________ Telephone: _____________________

Are you proficient in written English? Yes ___ No ___

Are you proficient in spoken English? Yes ___ No ___

EDUCATION: In chronological order, list ALL degrees for College and Graduate Schools. ***Please attach a copy of your medical school transcript***

Degree	Major/Discipline	School (Country, if outside U.S.)	Date(s) of Attendance	Graduation Year

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POST-GRADUATE POSITIONS: Please list all post-graduate experience including any residency and/or fellowship training programs.

Dates From/To	Positions	Name and Location of Institutions including Country	Supervisor/ Preceptor

EXPERIENCE: Please list below, in chronological order, all dermatology-related experience not mentioned above, including research experience.

Dates From/To	Position	Name and Location of Institution including Country	Supervisor/ Preceptor

OTHER PROFESSIONAL ACCOMPLISHMENTS AND AWARDS: Please list Memberships in Medical, Scientific, and Honorary Societies and Prizes and Awards.

In 500 words on a separate page, describe your career goals and how this Observership will help you attain these goals.

REFERENCES: Please provide the names and addresses of at least three physicians who will be writing letters of recommendation on your behalf. At least one should be a preceptor of your pre- or postdoctoral training and one should be your present Chairman or Chief.

Name and Position	Business Address
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

In completing this application I certify that all information in this application is true to the best of my knowledge.

I release from liability any physician or other person furnishing or reviewing information or making any recommendation in connection with this application for this program.

I hereby attest that I am mentally and physically healthy and have medical insurance and the proper visa to travel to the United States.

______________________________ ______________________

Signature of Applicant Date

Revised 2/2019

DC 11/5/2020