

The American Board of Dermatology, Inc.

MAILING ADDRESS

Henry Ford Health System
One Ford Place
Detroit, MI 48202-3450
313-874-1088

WEB SITE

www.abderm.org

Instructions for Completing the Application for Subspecialty Certification in Dermatopathology

1. Please complete **all** sections that pertain to your training or experience. If a section does not apply to you, type in "NA". Use extra pages if it is necessary to list additional data.

Return the completed printed form and all requested items to the Board office. It is recommended that you make and retain a copy for your records. If you were certified by the American Board of Dermatology, your application must be submitted to the ABD office; if you were certified by the American Board of Pathology, please send your application to the ABP office.

Before you begin, discuss the entire form with your program director and please read the application statement carefully. It is necessary that the program director responsible for your training sign the application.

If you have questions in regard to the prerequisites and requirements for the examination, consult The American Board of Dermatology *Booklet of Information*, available on the web site, or call the Board office.

2. It is a **requirement** that you possess a currently valid, full and unrestricted license to practice **medicine or osteopathy** in the state or province of your residence in either the United States or Canada. If your license is currently valid but due to expire on or before the examination date, you will be allowed to take the examination but must submit a copy of your renewed medical license as soon as it is available. A candidate may be denied certification if his/her licensure has been revoked, suspended, restricted, or surrendered in any jurisdiction – or if the candidate is subject to adverse licensure proceedings.
3. If your training has been in more than one training program, be sure to include as references all the directors of your programs and be certain that they are indicated as directors and that the addresses are complete and accurate.
4. **Cancellations.** If a candidate withdraws within ten (10) days of the examination or fails to appear for the examination and does not provide verifiable evidence of extenuating circumstances that prevented him/her from appearing for the examination, the candidate will forfeit the entire examination fee. Candidates must notify the Board office in writing regarding withdrawal from the examination; a withdrawal notification by telephone will not be accepted.
5. **Board Qualification.** An evaluation form will be sent to your program director(s). You will be responsible for having two reference letters sent to the Board by the individuals you have listed. When all the necessary documentation is received, your application will be reviewed by the Credentials Committee and you will be informed as to your qualification. This process takes approximately 6-8 weeks. An admittance form, hotel reservation card, and instructions will be mailed approximately six weeks prior to the examination date.

6. **Eligibility.** The Board does not recognize or use the term “board eligible” and does not issue statements concerning “board eligibility.” An applicant is declared qualified for examination only after an application has been received and approved by the Credentials Committee.
7. **Signatures.** The signature of the applicant is required on page 2 and on page 6. The signature of your dermatopathology training program director is required on page 6 and on the front of the two photographs.
8. **ID Photos.** All applications for subspecialty certification must be submitted with two photographs for ID purposes. One photo should be affixed to the space provided on the last page of the application. The second photo should be affixed to the identification card.

The program director must sign the front of the photographs, documenting that they represent the applicant. Applications that do not contain the program director signature on the application and on the photographs will be returned as incomplete.

American Board of Dermatology
 Henry Ford Health System
 One Ford Place
 Detroit, Michigan 48202-3450

WEB SITE
www.abderm.org

Revised 02/09/05

American Board of Pathology
 One Urban Centre, Suite 690
 4830 West Kennedy Boulevard
 Tampa, Florida 33609-2571

FOR OFFICE USE ONLY			
Date Received	Approved Training	Primary Cert.	License
Fee	Date Approved	References	

APPLICATION FOR SUBSPECIALTY CERTIFICATION IN DERMATOPATHOLOGY

- INSTRUCTIONS TO APPLICANTS**
1. Complete all sections in detail. If a section does not apply to you, type or print in "NA." Use extra pages if it is necessary to list additional information.
 2. Enclose application/examination fee in U.S. funds (check, money order, or credit card authorization). An application/examination fee is required for each and every examination. Make check payable to the American Board of Dermatology or the American Board of Pathology.
 3. Return completed application and all requested items to the American Board of Dermatology or the American Board of Pathology.

A. PERSONAL				
1. NAME	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">Last</td> <td style="width: 33%; border-bottom: 1px solid black;">First</td> <td style="width: 33%; border-bottom: 1px solid black;">Middle</td> </tr> </table>	Last	First	Middle
Last	First	Middle		
2. S.S. NO.				
3. ADDRESS	If Hospital or Medical Center, include name of Institution			
	Street			
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">City</td> <td style="width: 20%;">State</td> <td style="width: 40%;">Zip Code</td> </tr> </table>	City	State	Zip Code
	City	State	Zip Code	
	Telephone Number			
E-Mail Address				
4. GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female			
5. DATE OF BIRTH				

B. MEDICAL LICENSURE		
<p>You are to send a notarized copy of your current registration card (annual or biennial renewal) showing date of expiration of your full and unrestricted license to practice medicine. The medical license must be current at the time of the examination. List below the state(s) in the United States or the province(s) in Canada in which you are licensed, your license number(s), and expiration date(s).</p>		
State or Province	License Number	Expiration Date

APPLICATION FOR SUBSPECIALTY CERTIFICATION IN DERMATOPATHOLOGY

Page 2

APPLICATION STATEMENT

I hereby make application to The American Board of Dermatology (ABD) or The American Board of Pathology, Inc. (ABP) to sit for the examination in dermatopathology and for the issuance of a certificate thereto. I request and authorize the evaluation and validation of my credentials in accordance with, and subject to, the rules and regulations of the ABD and the ABP. I hereby release, discharge, covenant not to sue, and hold harmless the ABD, the ABP, their Trustees/Directors, officers, members, examiners, representatives, and agents from any actions, suits, claims, demands, or damages arising out of, or in connection with any action taken by any of them regarding this application, the gathering, collecting, and use of information about my practice or education, the grade or grades given with respect to any examination, the failure of the ABD or the ABP to certify me, or the revocation of any certificate. I understand that all decisions as to my credentials and qualification for admission to the examination and for certification rest solely and exclusively in the ABD and the ABP, and that their decision is final, and my exclusive appeal from any adverse decision by the ABD and ABP is pursuant to the rules and procedures of the ABD or the ABP, and the determination of any such appeal is final and binding.

I agree to disqualification from the examination and possibly from future examinations, to denial of certification, and to revocation of any certificate granted to me in the event that (a) I make any false statement or material omission in this application, (b) I fail to supplement, in a timely fashion, my response to any of the questions on this application which require supplementation, or (c) I violate any rule or policy of the ABD or ABP.

I understand that if, after investigation, the ABD or ABP has good reason to believe that I have engaged in cheating or irregular behavior in connection with the examination, whether or not such behavior had an effect on my performance, either Board may terminate my participation in the examination, invalidate my examination, refuse to certify me, bar me from retaking the examination in the future, or take other appropriate action. I also understand that the ABD or ABP may require me to retake one or more portions of the examination if it is presented with sufficient evidence that the security of the examination has been compromised, notwithstanding the absence of any evidence of my personal involvement in such activities.

I understand that the examination and all test questions are protected by copyright law. Because of the confidential and proprietary nature of these copyright materials, I agree not to retain, copy, disclose, or reveal any part of these examination materials.

I agree that the ABD or the ABP may release the results of my examination(s) to the director of my dermatopathology training program. I further agree that the ABD or the ABP may provide information to appropriate parties concerning my status as Board certified or not certified, dates and bases for action(s) related to my certification, and/or other appropriate information; all disclosures will be in compliance with the law.

I agree to be legally bound by the foregoing.

Signature

X

Please type your name here

Today's Date

APPLICATION FOR SUBSPECIALTY CERTIFICATION IN DERMATOPATHOLOGY

Page 4

Please type your name here

F. DERMATOPATHOLOGY TRAINING

(To Be Completed By **ALL** Applicants)

Give the number of dermatologic, pathologic, and dermatopathologic cases **for which you were responsible for the diagnosis of record** during your period of dermatopathology training. **Do not include** any of the period of training used for certification in dermatology or pathology.

A) Clinical Dermatology During Dermatopathology Fellowship	
1) Number of patients observed by you	
2) Number of patients directly under your care while supervised	
3) Number of patients biopsied by you	
B) Pathology Training During Dermatopathology Fellowship	
1) Number of non-dermatopathologic surgical pathology specimens examined by you	
C) Dermatopathology	
1) Specimens	
a) Total number of specimens accessioned in the training program during the last full year	
b) Total number of dermatopathologic specimens primarily diagnosed and reported by you while supervised	
c) Total number of specimens referred from outside the training program	
2) Did you participate in the sign out of Dermatopathology specimens throughout the year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Number of special dermatopathologic studies in which you were involved (see DP program requirements)	
a) Fluorescence microscopy	
b) Immunohistochemical	
4) Did you have experience in microbiological studies (including mycology and other microbiologic procedures)	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION FOR SUBSPECIALTY CERTIFICATION IN DERMATOPATHOLOGY

Page 5

Please type your name here

G. ADVERSE ACTIONS

1. Were you disciplined during your training? If yes, please provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have a history of use of chemical substances? If yes, please provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been censured by a hospital, state, or medical society? If yes, please provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever had your membership in a state or other medical society revoked, restricted, or denied? If yes, please provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever had your license to practice medicine restricted or revoked either through governmental action or voluntary surrender? If yes, please provide details below. You must inform the ABD of the details or your application will be denied.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever had your hospital medical staff membership or privileges revoked, restricted, or denied other than for Record Room deficiencies? If yes, please provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been convicted of a felony? If yes, please provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICATION FOR SUBSPECIALTY CERTIFICATION IN DERMATOPATHOLOGY

Page 6

H. REFERENCES AND SIGNATURES

List the name and **complete mailing address** of the **Director** of your dermatopathology training program in the United States from whom information may be obtained regarding this application. Give the name and complete mailing address of an ABP certified pathologist or ABD certified dermatologist for the second reference. **Two references must be supplied.**

For candidates submitting an application to the **American Board of Dermatology**, please request those listed as references below to send a letter of recommendation to the American Board of Dermatology as soon as possible so that your application will not be delayed.

For candidates submitting an application to **The American Board of Pathology**, a reference form will be sent to the references listed below.

1.	Name		
	If Hospital or Medical Center, include name of Institution		
	Street		
	City	State	Zip Code
	Telephone Number	Fax Number	
2.	Name		
	If Hospital or Medical Center, include name of Institution		
	Street		
	City	State	Zip Code
	Telephone Number	Fax Number	

In order to prevent any delay in the processing of your application, please request those listed above to promptly submit their letter of recommendation to the ABD office. Both references must respond before this application will be reviewed by the Credentials Committee.

Signature of Applicant

X

Please type your name here

Today's Date

As the applicant's dermatopathology training program director, I certify that the information given is true and represents the required training necessary to qualify to take the examination for subspecialty certification in dermatopathology.

Signature of Director of Training Program

X

Today's Date

Attach one of the two
PASSPORT SIZE
photographs
here.

The American Board of Dermatology, Inc.

Credit Card Authorization Form

Check one	Master Card _____ Visa _____
Name as it appears on the card (please print)	First _____ Middle _____ Last _____
Account Number	
Expiration Date	
Amount to be Charged	
Billing Address (please print)	Street _____ City _____ State & Zip Code _____
Cardholder's Signature	
Today's Date	

The American Board of Dermatology, Inc.

Identification Card Instructions

1. Please print your name on the identification card below.
2. Cut out the identification card on the dashed line.
3. Glue one of the two photographs signed by your Program Director to the identification card.
4. Sign the identification card.
5. Paper clip the identification card to the application form. Do NOT staple.



Please cut out the Identification Card on the dashed line



Last Name	First Name	Middle Name
-----------	------------	-------------

<p>Glue one recent photograph here, signed by your Program Director.</p> <p>This card must be completed, signed, and returned with the registration form.</p>	<p>AMERICAN BOARD OF DERMATOLOGY AMERICAN BOARD OF PATHOLOGY Identification Card</p> <hr/> <p>Signature</p>
---	---



Please cut out the Identification Card on the dashed line

