COSMETIC DERMATOLOGIC SURGERY FELLOWSHIP PROGRAM FELLOWSHIP PROGRAM APPLICATION FORM

(Please print or type.)

Applicant Information:

Name of Fellowship Program (Institution):_____

Fellowship Director Name: _____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone: _____

Secondary Address, if teaching will occur in more than one facility:

Address: _____

City: _____State:_____

Email Address: _____ Date of Birth:_____

Place of Birth: _____ Date of MD Degree: _____

Post-MD Training:

Internship:_____
Location Date

Residency:_____
Location Date

Post-residency:_____
Location Date

# of Years of Cosmetic Dermatologic Surgery Experience _____

Medical Licenses: _____

Specialty Board-certification:_____

Has any medical license been surrendered, suspended or revoked? ◯ Yes ◯ No

Have you ever been disciplined by any state or local medical board? ◯ Yes ◯ No

Have you ever been convicted of a felony? ◯ Yes ◯ No

Fellowship Program Start Date:_____

Number of Fellows: _____

Name(s) of Faculty Supporting the Fellowship Program:

_____

_____

_____

_____

Academic Appointments:

_____

_____

_____

Hospital Privileges:

_____

_____

National or Local Boards Served:

_____

_____

Publications:

_____

_____

_____

A. Number of Cases you Performed in the Last Calendar Year:

Procedures	**# Cases Performed**	**Procedures**	**# Cases Performed**
Wrinkles and Folds		Laser Lipolysis	
Fat Transfer *optional*		Ultrasound /Radiofrequency Fat Removal	
Neuromodulators		Tumescent Liposuction	
Soft Tissue Fillers *Must include specific training in all FDA approved types: poly-L-lactate, hyaluronic acid, and calcium hydroxylapatite fillers.*		Ultrasound/Radiofrequency Tissue Tightening	
Rejuvenation		Other Energy-based or Chemical Modalities	
Microdermabrasion		**Lifting**	
Non-ablative Laser and Light-based Treatments *Must include specific training in pigmented lesion lasers and vascular lasers.*		Brow Lift	
Non-ablative Fractional Resurfacing		Blepharoplasty	
Chemical Peels – Light		Facelift	
Resurfacing		**Hair Treatments**	
Chemical Peels – Medium-Deep		Hair Transplantation	
Ablative Laser Resurfacing		Hair Removal	
Dermabrasion		**Scar Revision**	
Fractional Laser Treatments		Fractional/Vascular Laser	
Veins		Keloid Excision	
Ambulatory Phlebectomy		Acne Scar Excision	
Laser Varicose Vein Surgery		Z-plasty	
Pulsed-light Therapy		Subcision	
Sclerotherapy		TCA/CROSS	
Body Contouring		Injection Treatment**	
Cryolipolysis			

**excluding intralesional corticosteroids, local anesthetics or injections elsewhere in this table .

B. Acknowledgement of Responsibilities:

As Fellowship Director, I acknowledge that by accepting a Fellow(s) for training, I am entering into a binding written contract with that Fellow and will be responsible for fulfilling the terms thereof.

I further acknowledge that I am solely responsible for each Fellow(s) completion of his/her/their training. I release the Cosmetic Dermatologic Surgery Fellowship Accreditation Program (CDSFAP) and the American Society for Dermatologic Surgery (ASDS), its officers, directors, members, or agents from all responsibility relating to each Fellow's training. I indemnify and hold CDSFAP and ASDS harmless for all damages resulting from the program in which I am a member of the faculty.

I agree to uphold the standards of the Accreditation Program and assume complete responsibility for Fellowship training by undertaking the following:

- ✓ Providing one calendar year of training in the office/facility of the Fellowship Director where the majority of time is spent training.
- ✓ Confirming participation of the minimum number of faculty required to teach the Fellow(s) as specified in the standards.
- ✓ Providing the Fellow(s) with at least 1,000 cases to observe, including at least 260 cases to perform/assist in five of the eight categories of procedures.
- ✓ Structuring a program that follows the Curriculum established by the CDSFAP.
- ✓ Monitoring the Fellow(s)' demonstrated achievement in the six (6) Core Competencies.
- ✓ Providing the Fellow(s) with experience teaching residents.
- ✓ Augmenting the Fellow(s) educational experience by supporting his/her attendance at national educational meetings.
- ✓ Assigning the Fellows(s) with the responsibility of writing a scientific article, reviewing at least two manuscripts for *Dermatologic Surgery*, and submitting an abstract for presentation at the ASDS Annual Meeting.
- ✓ Taking any and all other actions required to obtain and maintain accreditation as specified in the standards.

I understand that during the site visit, I will be expected to provide a current CV, for each faculty member, a teaching plan and prior Fellowship trainees' case logs. I will schedule a variety of observable cosmetic dermatologic surgery cases on the day of the site review and ensure that no other obligations conflict. I will make available any other documents and information requested by the Site Reviewer. In compliance with HIPAA regulations, I shall de-identify any patient records prior to disclosure to the Cosmetic Dermatologic Surgery Fellowship Accreditation Program or any of its designees.

I agree to maintain confidence and not disclose to, or discuss with, any other party any statements or decisions made regarding the application, site visit or accreditation decision at any point in the application and renewal process.

I represent that the information provided in this application is truthful and accurate.

Signature Date

Printed

C. Please provide a current copy of the curriculum vitae and evidence of malpractice insurance, including coverage for the Fellowship Program and its Fellows.

D. Fellowship Directors should include a brief 1-page overview of the planned structure of the proposed fellowship training program with the initial application documents.

E. Application should also contain a planned Fellow weekly schedule including assigned faculty and training location assignments.

Please submit payment with application form, CV, evidence of malpractice insurance, program overview and proposed Fellow weekly schedule to:

American Society for Dermatologic Surgery
Attn: Cosmetic Dermatologic Surgery Fellowship Accreditation Program (CDSFAP)
5550 Meadowbrook Drive, Suite 120
Rolling Meadows, IL 60008
Telephone: 847-956-0900 Fax - 847-956-0999
cdsfap@asds.net

COSMETIC DERMATOLOGIC SURGERY FELLOWSHIP PROGRAM
FACULTY APPLICATION FORM
(Please print or type)

Check one: ◯ **Associate Director** ◯ **Surgical Faculty**

A. Applicant Information:

Name:_____

Name of Fellowship Director:_____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone:_____

Email Address:_____

Date of Birth:_____ Place of Birth:_____

Date of MD Degree:_____ # of Years in Practice:_____

Post-MD Training: Internship:_____
Location Date
Residency:_____
Location Date
Post-residency:_____
Location Date

Medical Licenses: _____

Specialty Board-certification: _____

Has any medical license been surrendered, suspended or revoked? ◯ Yes ◯ No

Have you ever been disciplined by any state or local medical board? ◯ Yes ◯ No

Have you ever been convicted of a felony? ◯ Yes ◯ No

Academic Appointments: _____

_____

Hospital Privileges: _____

_____

B. Number of Cases you Performed in the Last Calendar Year:

Procedures	**# Cases Performed**	**Procedures**	**# Cases Performed**
Wrinkles and Folds		Laser Lipolysis	
Fat Transfer *optional*		Ultrasound /Radiofrequency Fat Removal	
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Rejuvenation		Other Energy-based or Chemical Modalities	
Microdermabrasion		**Lifting**	
Non-ablative Laser and Light-based Treatments *Must include specific training in pigmented lesion lasers and vascular lasers.*		Brow Lift	
Non-ablative Fractional Resurfacing		Blepharoplasty	
Chemical Peels – Light		Facelift	
Resurfacing		**Hair Treatments**	
Chemical Peels – Medium-Deep		Hair Transplantation	
Ablative Laser Resurfacing		Hair Removal	
Dermabrasion		**Scar Revision**	
Fractional Laser Treatments		Fractional/Vascular Laser	
Veins		Keloid Excision	
Ambulatory Phlebectomy		Acne Scar Excision	
Laser Varicose Vein Surgery		Z-plasty	
Pulsed-light Therapy		Subcision	
Sclerotherapy		TCA/CROSS	
Body Contouring		Injection Treatment**	
Cryolipolysis			

**excluding intralesional corticosteroids, local anesthetics or injections elsewhere in this table .

C. Acknowledgement of Responsibilities:

As a Surgical Faculty member of the Fellowship Program, I acknowledge that the approved Fellowship Director is solely responsible for each Fellow's completion of his/her training. I release the Cosmetic Dermatologic Surgery Fellowship Accreditation Program (CDSFAP) and the American Society for Dermatologic Surgery (ASDS), its officers, directors, members, or agents from all responsibility relating to each Fellow's training. I indemnify and hold CDSFAP and ASDS harmless for all damages resulting from the program in which I am a member of the faculty.

I agree to maintain confidentiality and not disclose to, or discuss with, any other party any statements or decisions made regarding the application, site visit or accreditation decision at any point in the application and renewal process.

I represent that the information provided in this application is truthful and accurate.

_____

Signature Date

_____

Printed

D. Please provide a current copy of the curriculum vitae.

Please submit payment (if you are joining an already approved program) with application form and CV to:

American Society for Dermatologic Surgery
Attn: Cosmetic Dermatologic Surgery Fellowship Accreditation Program (CDSFAP)
5550 Meadowbrook Drive, Suite 120
Rolling Meadows, IL 60008
Telephone: 847-956-0900 Fax - 847-956-0999
cdsfap@asds.net

COSMETIC DERMATOLOGIC SURGERY FELLOWSHIP PROGRAM
FELLOWSHIP DIRECTOR ACKNOWLEDGEMENT/HOLD HARMLESS FORM

(Please print or type.)

Program Director Name: _____

Please complete:

_____# of Fellow(s) accepted for 1-year program beginning _____through_____ (enter dates).

Name of Fellow:_____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone:_____

Email Address:_____

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Name of Fellow:_____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone:_____

Email Address:_____

==========

Name of Fellow:_____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone:_____

Email Address:_____

As a Fellowship Director, I acknowledge that by accepting a Fellow(s) for training, I am entering into a binding written contract with the Fellow(s) and will be responsible for fulfilling the terms thereof.

I further acknowledge that I am solely responsible for each Fellow's completion of his or her training. I release the American Society for Dermatologic Surgery (ASDS) and its officers, directors, members, or agents from any and all responsibility relating to each Fellow's training. I indemnify and hold CDSFAP and ASDS harmless for any damages resulting from the program in which I am the Fellowship Director.

I represent that the information provided in this application is truthful and accurate.

_____

Printed Name of Program Director Signature of Program Director

_____

Date

Please return to:

American Society for Dermatologic Surgery
Attn: Cosmetic Dermatologic Surgery Fellowship Accreditation Program (CDSFAP)
5550 Meadowbrook Drive, Suite 120
Rolling Meadows, IL 60008
847-956-0900 - Fax - 847-956-0999
cdsfap@asds.net

COSMETIC DERMATOLOGIC SURGERY FELLOWSHIP
PROGRAM FEES

(Effective 1.1.2020)

Check appropriate category:

◯	$2,750/$3,750	Initial Accreditation Fee (includes site review for 1 training location)
◯	$2,000/$3,000	Site Review Fee (Change, Probationary, Additional training site)
◯	$1,500/$2,000	Cyclical Review Fee (At ASDS Annual Meeting)
◯	$650	Annual Maintenance of Accreditation Fee (Base)
◯	$600	Annual Maintenance of Accreditation Fee (per Fellow)
◯	$150/$225	Post-accreditation Faculty Change Fee*

**If the application(s) for faculty are submitted separate from initial accreditation application.*

Name:_____ ASDS Member ID:_____

Address: _____

City:_____State:_____

Telephone:_____Cell Phone:_____

Email Address:_____

Method of Payment

◯ Check enclosed, payable to the American Society for Dermatologic Surgery.

Credit card payment: ◯ MasterCard ◯ Visa ◯ American Express ◯ Discover

_____

Card Number Expiration Date Billing Zip Code

_____

Printed Name (as it appears on card) Signature

_____

Date

American Society for Dermatologic Surgery
Attn: Cosmetic Dermatologic Surgery Fellowship Accreditation Program (CDSFAP)
5550 Meadowbrook Drive, Suite 120
Rolling Meadows, IL 60008
847-956-0900 - Fax - 847-956-0999
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