Established in 1939, the agency is considered "one of the model Statewide Medicolegal Death Investigative Systems" and has one of the longest running forensic fellowship programs in the United States. Under the supervision of board-certified or board-eligible forensic pathologists, the fellow will perform postmortem examinations to determine the cause and manner of death in a wide variety of cases which occur in both urban and rural settings. The OCME investigates sudden unexpected and traumatic deaths, approximately 18,000 per year, in 23 counties. Approximately 6,000 postmortem examinations were conducted in 2020. A comprehensive curriculum includes daily morning and afternoon rounds, didactic lectures, journal clubs, and pending/consensus conferences. Scene investigations, rotations within the in-house toxicology lab, formal rotations with a local Crime Lab, forensic anthropology, forensic neuropathology, and cardiovascular pathology are also included. Courtroom testimony is strongly encouraged, first by shadowing attending medical examiners and followed by the fellow’s own testimony later in the year. The office is within walking distance to the University of Maryland Medical Center and School of Medicine and is easily accessible to The Johns Hopkins University Hospital. As a state employee, the fellow receives benefits such as health insurance, vacation, and sick time. Fellows are provided private office space along with protected time and funding to attend at least one national meeting.

**Requirements:** Successful completion of an accredited pathology residency training program in either Anatomic Pathology or combined Anatomic/Clinical Pathology.

Stephanie A. Dean, M.D.
Fellowship Program Director
Office of the Chief Medical Examiner
900 W. Baltimore Street
Baltimore, MD 21223
fellowship@ocmemd.org
APPLICATION FOR FELLOWSHIP TRAINING
OFFICE OF THE CHIEF MEDICAL EXAMINER
900 W. BALTIMORE STREET
BALTIMORE, MARYLAND 21223
(410) 333-3250
fellowship@ocmemd.org

Fellowship from_________________ to ____________________

Name in Full___________________________________________ S.S.#___________________________

Age ________ Date of Birth _______________________ Place of Birth ___________________________

If Not U.S. Citizen, Type of Passport or Visa _________________________________________________

If Naturalized U.S. Citizen, Date ___________________________________________________________

Sex: M _________ F_________ Marital Status__________________ Number of Dependents __________

Telephone: Home_______________________________ Office __________________________________

Email Address: ________________________________________________________________________

Present Address ________________________________________________________________________

Permanent Address  _____________________________________________________________________

________________________________________________________________________

Medical School __________________________________________ Year of Graduation ______________

College or University _________________________________________________________________

Number Years Attended ________________________ Degree and Date ____________________________
Internships, Residencies, Fellowships:

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<th>To</th>
<th>Head of Department</th>
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Other Post-Graduate Training ___________________________________________________________
_____________________________________________________________________________________

Research Experience ________________________________________________________________
_____________________________________________________________________________________

What licenses to practice medicine do you hold?

National Board _______________________________ Date of Acquisition _________________________
State Board (State) ____________________________ Date of Acquisition _________________________
State Board (State) ____________________________ Date of Acquisition _________________________
State Board (State) ____________________________ Date of Acquisition _________________________

Served in U.S. Armed Forces?

Branch of Service _______________________________ Capacity _______________________________
Dates of Service _______________________________

Are you in good physical condition? Yes ____________ No ____________ If you have any physical defect or abnormality, describe ____________________________________________________________
_____________________________________________________________________________________

(2)
American Board of Pathology Certificate? Yes ___________________ No _________________________

Pathology Anatomy _______________________________ Date _________________________________

Clinical Pathology ________________________________ Date _________________________________

Other __________________________________________ Date _________________________________

What Medical Societies are you a member in good standing?

________________________________________________ Date of Admission _____________________

________________________________________________ Date of Admission _____________________

________________________________________________ Date of Admission _____________________

Give name and address of three (3) persons for references. Include present employer, no relatives.

Name    Address   City - State

1. ___________________________________________________________________________________

2. ___________________________________________________________________________________

3. ___________________________________________________________________________________

List your publications:

1. 

2. 

3. 

________________________________ ___________________________________________

Date of Application    Signature of Applicant

Please also provide: three letters of recommendation, an updated curriculum vitae, a personal statement, and a recent photo (head and shoulders). All materials may be sent to fellowship@ocmemd.org

(3)