International Residents and Fellows Membership Application

FIRST NAME ______ MI ______ LAST NAME (FAMILY NAME) ______ DATE OF APPLICATION ______

ADDRESS LINE 1 ______

ADDRESS LINE 2 ______

CITY ______ STATE/ PROVINCE ______ COUNTRY ______ POSTAL CODE ______

TELEPHONE ______ CELL PHONE ______ EMAIL ______

Gender ☐ Male ☐ Female

Date of Birth (DD/MM/YY):______

Name of Medical School (University) ______

Graduated/Completed Month/Year______

General Surgery (Name of Hospital/Institution)______

General Surgery Start Month/Year______General Surgery End Month/Year______

Plastic Surgery Training Information: Choose one

☐ Plastic Surgery (residency) Start Month/Year______Plastic Surgery End Month/Year______

☐ Fellowship Start Month/Year______Plastic Surgery End Month/Year______

Name of Hospital/Institution______

Hospital/Institution Address Line 1 ______

Hospital/Institution Address Line 2 ______

City ______ State/ Province ______ Country ______ Postal Code ______

Training Program Director Name: ______

Training Program Director Phone:______ Email: ______

To be signed by your Training Program/ Hospital Residency Director:
I certify that the above named resident is enrolled in a plastic surgery training program during the indicated time frame.

____ _______________
SIGNATURE – TRAINING PROGRAM / HOSPITAL RESIDENCY DIRECTOR DATE

Subscriptions are valid for one year and are renewable annually or until end of Residency or Fellowship training. Please submit a letter of recommendation from your training program director affirming that you are currently on the program.

Authorization to Release Information

While an Applicant for Membership and if elected to membership in the American Society of Plastic Surgeons® (ASPS or the "Society"), I agree to abide by the Society's Bylaws and Code of Ethics. I understand that membership in ASPS is a privilege and not a right. As an applicant for membership, I have the responsibility of providing information adequate for proper evaluation of my fitness for membership in ASPS.

In furtherance of my application for membership in ASPS, I hereby request and authorize any hospital, any medical staff, any medical organization and any person who may have information (including medical records, patient records and reports of committees) that they deem relevant to my fitness for membership to provide such information to the Society. I further authorize the Society to provide any information it receives in connection with my application for membership in the Society to a state or county licensing authority, a state or county medical association, or an accrediting body provided I have authorized the licensing authority, medical association, or accrediting body to obtain such information.

The Society shall not be liable for acts performed in connection with the collection, evaluation, or dissemination of information or opinions, whether or not requested or solicited, in connection with my application for membership in the Society. I shall not demand, through any judicial process, access to any information accumulated or prepared by the Society in considering my application for membership.

Name (Printed): ____

Signature:_______________________________________ **Date:** ___________________

Please submit application and letter of recommendation from your training program director to:
ASPS Member Services
American Society of Plastic Surgeons
444 E. Algonquin Road
Arlington Heights, IL 60005-4664
Or email to: membership@plasticsurgery.org
Or fax to: +001 847-228-7099

2020/02