



## **Allied Health Affiliate Membership Application Information**

The mission of the American Society of Plastic Surgeons is to advance the quality of care delivered to plastic surgery patients by encouraging the highest standards of training, ethics, physician practice management and research in plastic surgery. The Society's core values embody excellence in plastic surgery through education, research, intellectual exchange and by promoting unity in the specialty of plastic surgery.

Allied Health Affiliate Membership may be conferred upon non-physician health care professionals who support the plastic surgery team, including but not limited to nurses, physician assistants, research assistants, residency coordinators, surgical technologist and/or assistants.

### **As an Allied Health Affiliate member, you will receive the following educational benefits:**

- Access to members-only content at [www.plasticsurgery.org](http://www.plasticsurgery.org)
- Digital subscription to *Plastic Surgery News* (PSN)
- Full access to *ASPS Education Network* (ASPS EdNet) for online clinical education, including the coding guide book
- CME opportunities for Physician Assistants
- Optional discounted subscription to the journal *Plastic and Reconstructive Surgery* (PRS)
- Reduced registration fee for *Plastic Surgery The Meeting* (PSTM)
- Member pricing on ASPS/PSF products and services



AMERICAN SOCIETY OF  
PLASTIC SURGEONS®

## Allied Health Affiliate Membership Application

\$134 to cover ONE (1) year of dues

Receive the *Plastic & Reconstructive Surgery* Journal for **\$175.00**

Name (Please Print): \_\_\_\_\_

Gender: Male  Female  Date of Birth: \_\_\_\_\_

Job Title: \_\_\_\_\_

### Mailing Address

Street Address 1: \_\_\_\_\_

Street Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

ASPS Member Physician: \_\_\_\_\_ ASPS Member Id#: \_\_\_\_\_

Telephone Number (Employer): \_\_\_\_\_ Fax Number (Employer): \_\_\_\_\_

#### To be signed by your ASPS Member Physician:

I certify that the above-named applicant is of high moral, ethical and professional competence and is employed by or works directly with an ASPS Member Physician.

\_\_\_\_\_  
SIGNATURE - ASPS MEMBER

\_\_\_\_\_  
DATE

**Please retain a copy for your records.**

**Submit a sponsorship letter from an active member of the Society.**

**Payment method will be sent after the application is submitted.**

### **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 sponsorship from an active member of the Society to:**

ASPS Member Services

American Society of Plastic Surgeons

444 E. Algonquin Road

Arlington Heights, IL 60005-4664

Or email to: [membership@plasticsurgery.org](mailto:membership@plasticsurgery.org)