AMERICAN SOCIETY OF PLASTIC SURGEONS®

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 _____ PERSONAL EMAIL _____ SCHOOL 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:** _____

☐ I have additional information that may be necessary for a proper evaluation of my fitness for membership by the Society (previous disciplinary actions, license revocations, etc.) and I will provide the necessary documentation, upon request.

☐ I have no additional information to provide that would affect my fitness for membership with the Society.

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