

MIDWESTERN ASSOCIATION OF PLASTIC SURGEONS

APPLICATION FOR MEMBERSHIP

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____ SEX: _____

DATE OF BIRTH: _____ BIRTHPLACE: _____ CITIZENSHIP: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

RESIDENCE ADDRESS: _____ CITY: _____ ZIP CODE: _____

OFFICE ADDRESS: _____ CITY: _____ ZIP CODE: _____

RESIDENCE TELEPHONE: _____ OFFICE TELEPHONE: _____

MEDICAL EDUCATION: MEDICAL SCHOOL: _____

DEGREE: _____ DATE OF GRADUATION: _____

RESIDENCY AND FELLOWSHIPS

HOSPITAL: _____ SPECIALTY: _____ DATES: _____

HOSPITAL: _____ SPECIALTY: _____ DATES: _____

HOSPITAL: _____ SPECIALTY: _____ DATES: _____

HOSPITAL: _____ SPECIALTY: _____ DATES: _____

CERTIFICATIONS

BOARD OF PLASTIC SURGEONS: _____ DATE: _____

F.R.C.S. (C): _____ DATE: _____

OTHER BOARDS: _____ DATE: _____

LICENSURE

STATE: _____ DATE: _____ LICENSE NUMBER: _____

STATE: _____ DATE: _____ LICENSE NUMBER: _____

DO YOU HAVE A VALID LICENSE TO PRACTICE MEDICINE ? _____

TEACHING APPOINTMENT: (UNIVERSITY): _____ RANK: _____ DATE: _____

(OVER)

HOSPITAL STAFF APPOINTMENTS: _____

MEMBERSHIP IN THE AMERICAN SOCIETY OF PLASTIC SURGEONS ??: Yes _____, No _____

MEMBERSHIP IN MEDICAL SOCIETIES (LIST): _____

PLEASE ATTACH A RECENT PHOTO

IF ELECTED TO MEMBERSHIP IN THE MIDWESTERN ASSOCIATION OF PLASTIC SURGEONS, I AGREE TO ABIDE BY ITS BYLAWS AND SUCH RULES AND REGULATIONS AS IT MAY FROM TIME TO TIME ENACT.

DATE: _____ SIGNATURE: _____



ACTION OF COORDINATOR: REFERENCES: 1. _____ 2. _____

COMMENTS:

DATE MAILED TO MEMBERSHIP CHAIRMAN: _____

ACTION OF THE MEMBERSHIP COMMITTEE: _____ DATE: _____

ACTION OF THE SOCIETY MEMBERSHIP: _____ DATE: _____

DATE OF NOTIFICATION TO APPLICANT OF MEMBERSHIP STATUS: _____

PLEASE RETURN COMPLETED FORM TO:
Cheryl Matthews, Executive Secretary
Division of Plastic Surgery,
Southern Illinois University
Springfield, Illinois