The Wisconsin Surgical Society

A Chapter of the American College of Surgeons

Application for Membership

Please attach to your dues payment form.

Dues $125 per year

Dues year January 1 through December 31

Name ____ Date __________

Office Address ____

Phone ______________ FAX ________________ Email ____________________

Place and date of birth ____

Are you a Fellow of the American College of Surgeons Yes ________ Date ____________

I am an applicant/candidate to be a Fellow of the American College of Surgeons.
Anticipated Fellow Year ____________

PREMEDICAL EDUCATION	**Dates (Inclusive)**	**Degree**
College ____________________	__________	____________________
College ____________________	__________	____________________

MEDICAL EDUCATION	**Dates (Inclusive)**	**Degree**
University __________________	__________	____________________
University __________________	__________	____________________

POST GRADUATE TRAINING	**Dates (Inclusive)**
Hospital ______________________________	________________
Hospital ______________________________	________________
Hospital ______________________________	________________

TEACHING APPOINTMENTS	**Dates (Inclusive)**
University ____________________________	________________
University ____________________________	________________

HOSPITAL STAFF APPOINTMENTS **Type of Appointment** **Dates (Inclusive)**

Hospital ______________________________ ___________________ ______________________

Hospital ______________________________ ___________________ ______________________

Hospital ______________________________ ___________________ ______________________

Hospital ______________________________ ___________________ ______________________

CERTIFICATION SPECIALTY BOARD(S) **Dates**

Board Name ____ ______________________

Board Name ____ ______________________

MEMBERSHIP in MEDICAL SOCIETIES **Dates**

Society ____ ______________________

Society ____ ______________________

Society ____ ______________________

PUBLICATIONS **JOURNAL** **Dates**

Title ______________________________ ______________ ____________________________

Title ______________________________ ______________ ____________________________

Title ______________________________ ______________ ____________________________

Title ______________________________ ______________ ____________________________

ENDORSEMENT BY PRACTICING WSS Active MEMBER SURGEON

Member Name _______________________________________, M.D., FACS Date __________

Please print your name if your signature is difficult to decipher.

I, _____________________________________ , (please your print name) do hereby make application for membership in The Wisconsin Surgical Society, A Chapter of the American College of Surgeons. I consent to practice in an ethical manner.

____, M.D. Date _________________________