THE WISCONSIN SURGICAL SOCIETY

Chapter of the American College of Surgeons

Member Application Form

Dues year January 1 through December 31

Please type or print legibly.

Application Date ____

Name ____

Address ____

Municipality ______________________ State __________ Zip ______________

Phone ______________ FAX ______________ Email ______________________

√ Box	Membership Category	Explanation	Dues Amount
	Applicant	Current ACS Fellow - State Resident _________ FACS year	$125
	Associate	Current Associate Fellow of ACS – State Resident Anticipated__________FACS year	$125
		AMOUNT ENCLOSED	

Current Active Members have the opportunity to vote on the proposed Membership Ballot during the Annual Meeting held in conjunction with the November Conference.

Thank you for your continued participation in The Wisconsin Surgical Society, A Chapter of the American College of Surgeons. Please return this form, along with your dues payment to:

The Wisconsin Surgical Society
A Chapter of the American College of Surgeons
Jeanette May, Executive Director
26 S Henry St
Madison, WI 53703

_______ Check or Credit card ___ MC_____VISA ___ AMEX

Number______________________________________ Exp. Date_____/ _____ Authorization Code_____________

Name as it appears on credit card

____

Address______________________________________Municipality ________________________________

State______Zip______________Phone_________________Email ____________________________________

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 __________

In addition to the signature, please print the name of your endorsing sponsor if the signature is too difficult to read.

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 _________________________