**

**Checklist**

(for office use only)

* Application
* Release form (page 3)
* Case log
* $75 application fee
* Letter of recommendation

**APPLICATION FOR INTERNATIONAL AFFILIATE MEMBERSHIP**

**I,** *(print full name)* Click here to enter text. **hereby apply for membership**

|  |  |
| --- | --- |
| **Birth Date:** *(MM/DD/YYYY)* Click here to enter text. | **Gender:** [ ] **Male** [ ] **Female** |
| **Citizenship**: Click here to enter text. | **Birthplace:** Click here to enter text. |
| **Current Office Address**: *(Include facility name)* | **Current Home Address:** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| **Office phone**: Click here to enter text.*Include city/country codes* | **Home phone**: Click here to enter text.*Include city/country codes* |
| **Office email**: Click here to enter text. | **Home email**: Click here to enter text. |
| **Office fax**: Click here to enter text. | **Send mail to my:** [ ] **Home** [ ] **Office** |
| **CURRENT MEDICAL LICENSING:** |  |
| **License Location**: Click here to enter text. | **Expiration Date**: Click here to enter text. |
|  **License issued by**: *(governing body)* Click here to enter text. |
| **License Location**: Click here to enter text. | **Expiration Date**: Click here to enter text. |
|  **License issued by**: *(governing body)* Click here to enter text. |
| **Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked or surrendered?**[ ] **Yes** [ ] **No** **If yes, list details below**:Click here to enter text. |
| **MEMBERSHIP IN OTHER SPECIALTY AND MEDICAL SOCIETIES**: *(Attach list if more space is needed)* |
| **Society**: Click here to enter text. | **Dates of membership**: Click here to enter text. |
| **Society**: Click here to enter text. | **Dates of membership**: Click here to enter text. |
| **Society**: Click here to enter text. | **Dates of membership**: Click here to enter text. |
| **HOSPITAL AFFILIATIONS**: *(Current and past)* |
| **Name**: Click here to enter text. | **Location**: Click here to enter text. | **Dates**: Click here to enter text. |
| **Name**: Click here to enter text. | **Location**: Click here to enter text. | **Dates**: Click here to enter text. |
| **Name**: Click here to enter text. | **Location**: Click here to enter text. | **Dates**: Click here to enter text. |
| **BOARD OR SPECIALTY CERTIFICATIONS**: *(Attach list if more space needed)* |
| **Specialty or certification**: Click here to enter text. | **Date**: Click here to enter text. |
|  **Issued by**: *(governing body)* Click here to enter text. |
| **Specialty or certification**: Click here to enter text. | **Date**: Click here to enter text. |
|  **Issued by**: *(governing body)* Click here to enter text. |
| **MEDICAL TRAINING:** |  |
| **Medical School**: |  |
| **Name**: Click here to enter text. | **Location**: Click here to enter text. | **Dates**: Click here to enter text. |
| **Internship**: |  |
| **Name**: Click here to enter text. | **Location**: Click here to enter text. | **Dates**: Click here to enter text. |
| **Residency Training**: |  |
| **Name**: Click here to enter text. | **Location**: Click here to enter text. | **Dates**: Click here to enter text. |
| **Name**: Click here to enter text. | **Location**: Click here to enter text. | **Dates**: Click here to enter text. |
| **TOTAL TRAINING IN MICROGRAPHIC SURGERY:** |  |
| **Facility/Institution**: Click here to enter text. |
| **Location**: Click here to enter text. |
| **Director of Micrographic Surgery Program**: Click here to enter text. |
| **Program Start Date**: Click here to enter text. | **Program End Date**: Click here to enter text. |
| **Program Type:** [ ] **Full time intensive** [ ] **Part time intensive Number of days per week: Click here to enter text.** |
| **Completion of Advanced Cardiac Life Support or equivalent program:** [ ] **Yes** [ ] **No** |
| **Articles published/Teaching experience**: *(Attach list if more space needed)* |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| **EMPLOYMENT HISTORY:** |  |
| **Company/Facility Name**: Click here to enter text. | **Location**: Click here to enter text. |
|  **Dates**: Click here to enter text. | **Position**: Click here to enter text. |
| **Company/Facility Name**: Click here to enter text. | **Location**: Click here to enter text. |
|  **Dates**: Click here to enter text. | **Position**: Click here to enter text. |
| **Company/Facility Name**: Click here to enter text. | **Location**: Click here to enter text. |
|  **Dates**: Click here to enter text. | **Position**: Click here to enter text. |

**The following must be submitted in addition to this application in order to be considered for approval:**

* Case log containing 500 cases as outlined by International Affiliate Case Log guidelines
* Letter of nomination or recommendation to be sent separately by an Associate, Fellow, or Life Member of the ACMS who is currently in good standing
* **$75 USD** non-refundable application fee
* Information/Liability Release Form

**INFORMATION/LIABILITY RELEASE FORM**

I, (name) Click here to enter text., hereby apply for International Affiliate membership in the American College of Mohs Surgery (hereinafter referred to ACMS).

In consideration of ACMS processing my application for membership, I hereby grant permission for the ACMS to obtain information regarding hospital staff privileges and actions relating thereto, information from former medical society affiliations, specialty organizations, medical schools and other organizations providing medical training including internship and residencies.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character and ethical qualifications to all hospitals and medical licensing and discipline boards who request such information.

I hereby release and hold harmless from any liability or loss the ACMS, its officers, agents, employees and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the ACMS, to its authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further release from liability the ACMS, its officers, agents, employees and members for delivery of information to any third party as authorized herein provided such delivery occurs prior to the acknowledged receipt, in the office of the ACMS, of a written notice of revocation of this release.

I hereby agree to abide by the Bylaws of the ACMS and agree upon acceptance that my membership in the ACMS shall be conditional upon continued compliance with the aforementioned Bylaws.

*I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should this application contain any false or misleading information, my application may be rejected or, if approved, my membership with the American College of Mohs Surgery will be terminated.*

Signature Click here to enter text. Date Click here to enter text.