



American College of Mohs Surgery

Fellowship trained skin cancer and reconstructive surgeons

APPLICATION FOR FELLOW MEMBER STATUS

Checklist	
<input type="checkbox"/>	Application
<input type="checkbox"/>	Member of the Mohs College for at <u>least</u> (3) three years.
<input type="checkbox"/>	Case log of-300 cases *only cases completed <u>after</u> end of fellowship training are eligible or
<input type="checkbox"/>	Case Log Already Submitted

I, (Please print) _____ hereby apply for Fellow Member Status.

Degree or Title: _____

Office Address

Home Address

Office Phone: _____
Include country/city codes

Home Phone: _____
Include country/city codes

Office Fax: _____
Include country/city codes

Send College mail to my: Office _____ Home _____

E-mail Address: _____

Medical Licensing:

State: _____ Exp: _____

State: _____ Exp: _____

State: _____ Exp: _____

Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked or surrendered? Yes () No () If yes, list details on a separate piece of paper.

Total Training in Micrographic Surgery:

Location: _____

Fellowship Training Program Director: _____

Fellowship start date (dd/mm/yy): _____ Fellowship end date (dd/mm/yy): _____

[Note: Only cases completed after the end of applicant's training date will count towards the 300 needed to fulfill application requirements]

American College of Mohs Surgery

INFORMATION/LIABILITY RELEASE FORM

I _____, hereby apply for membership in the American College of Mohs Surgery. (Hereafter referred to as 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, the American Medical Association, appropriate State medical societies, 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 provide 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 of the aforementioned Bylaws.

I HEREBY AFFIRM AND REPRESENT THAT ALL STATEMENTS, ANSWERS AND INFORMATION CONTAINED IN THIS APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature _____ Date: _____

Return this completed application by **August 1st** to:

American College of Mohs Surgery
555 East Wells Street
Suite 1100
Milwaukee, WI 53202-3823
info@mohscollege.org
Fax: (414) 276-2146