



American College of Mohs Surgery

Fellowship trained skin cancer and reconstructive surgeons

Checklist	
<input type="checkbox"/>	Application
<input type="checkbox"/>	Release form
<input type="checkbox"/>	Case log (CD-ROM)
<input type="checkbox"/>	Faculty listed below, and on case log, are <u>approved</u> Mohs College Faculty
<input type="checkbox"/>	\$65 application fee
<input type="checkbox"/>	Letter of recommendation (sent directly to ACMS)
<input type="checkbox"/>	Signature verifying submission of scientific article

APPLICATION FOR MEMBERSHIP

I, (Please print) _____ hereby apply for membership.

Birth Date: _____ Gender: M () F () Birth Place: _____

Citizenship: _____ Degree or Title: _____

Office Address

Home Address

Office Phone: _____ Home Phone: _____
Include country/city codes

Office Fax: _____ Send College mail to my: Office _____ Home _____
Include country/city codes

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: _____

Director of Micrographic Surgery Program: _____

Associate Director (if listed on case log) _____

Surgical Faculty (if listed on case log) _____

Location

Date of Program (please circle indicating full or part-time)

_____	_____	Yes	No	Full Time Intensive
_____	_____	Yes	No	1, 2 ,3 days per week
_____	_____	Yes	No	Part Time Intensive
_____	_____	Yes	No	1, 2 ,3 days per week

Medical Training:

Medical School: _____ Date: _____

Internship: _____ Date: _____

Residency Training: _____ Date: _____

_____ Date: _____

Board Certification:

Specialty: _____ Date: _____ State: _____

Specialty: _____ Date: _____ State: _____

Specialty: _____ Date: _____ State: _____

Specialty Societies:

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

Membership in other medical societies:

Society: _____ Date _____

Society: _____ Date _____

Society: _____ Date _____

(Attach list if more space is needed)

Hospital Affiliations:

Name & Location: _____

Name & Location: _____

Verification of Article Submission:

My signature below verifies that I will submit a scientific article for publication within six months of completing my fellowship training program. (*The Program Director must also verify submission by his/her signature)

Signature: _____ Date: _____

Signature of Program Director: _____ Date: _____

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: _____

Fees/Forms

Your application must include a **\$65 non-refundable application fee and the Information/Liability Release Form**. Annual dues for the American College of Mohs Surgery are \$550 for physicians residing in the United States/\$350 for physicians residing outside of the United States.

A LETTER OF RECOMMENDATION FROM THE DIRECTOR OF THE FELLOWSHIP TRAINING PROGRAM IS REQUIRED AND MUST BE MAILED DIRECTLY TO THE COLLEGE'S EXECUTIVE OFFICE.

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

American College of Mohs Surgery
555 East Wells Street
Suite 1100
Milwaukee, WI 53202-3823
info@mohscollege.org