American College of Mohs Surgery

*Fellowship trained skin cancer and reconstructive surgeons*

**Checklist**

- ❑ Application
- ❑ Release form (page 3)
- ❑ Copy of ACLS card
- ❑ Case log
- ❑ Faculty listed below, and on case log, are approved ACMS or ACGME Faculty
- ❑ $75 application fee
- ❑ Letter of recommendation from from your Program Director (Sent directly to ACMS)
- ❑ Signatures verifying submission of scientific article (page 2)

# 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 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 **$75** non-refundable application fee and the Information/Liability Release Form. Annual dues for the American College of Mohs Surgery are $750 for physicians residing in the United States/$550 for physicians residing outside of the United States. You will be charged prorated dues after you are approved at the next Annual Meeting.

**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