American College of Mohs Surgery

Fellowship trained skin cancer and reconstructive surgeons

Checklist

- ❑ Application
- ❑ Release form
- ❑ Case log (CD-ROM)
- ❑ Faculty listed below, and on case log, are approved Mohs College Faculty
- ❑ $50 application fee
- ❑ Letter of recommendation (sent directly to ACMS)
- ❑ 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

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Home Address

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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: ____

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**)**

Location	Date of Program			
____________________	__________	**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 **$50** non-refundable application fee and the Information/Liability Release Form. Annual dues for the American College of Mohs Surgery are $450 for physicians residing in the United States/$275 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