

The American Society of Colon and Rectal Surgeons

MEMBERSHIP REQUIREMENTS AND APPLICATION

CANDIDATE

Candidate applications are accepted upon completion of requirements



85 WEST ALGONQUIN ROAD, SUITE 550
ARLINGTON HEIGHTS, IL 60005

PHONE: (847) 290-9184

FAX: (847) 290-9203

Website: www.fascrs.org

E-mail: ascrs@fascrs.org

MEMBERSHIP REQUIREMENTS

To eligible for Candidacy in the American Society of Colon & Rectal Surgeons the applicant must be actively enrolled in an accredited residency program in general surgery or colon and rectal surgery. This membership category is renewable annually contingent upon the Candidate's continued enrollment in a residency program as evidenced by the signature of the program director, or by such other means as the Executive Council may from time to time determine. Upon completion of residency training the Candidate may apply for Membership in the Society iff he/she meets the qualifications for that category of membership.

Please note: An unsigned application will not be processed.

CANDIDATE APPLICATION

ID #

For Office Use

PLEASE PRINT OR TYPE

Name _____ MD DO
(first) (middle) (Last) Other (specify) _____

Citizenship _____ Place of Birth _____ Date of Birth _____ Sex: M F

Social Security # _____ Spouse's Name _____

Primary Office Address _____

City _____ State _____ Zip _____ Country _____

Office Phone (____) _____ Office E-mail _____

Office Fax (____) _____ Web Site _____

Please list additional office addresses on a separate sheet and attach. While your home address and phone number will be retained on file, they will NOT be published, unless no office address is available.

Home Address _____

City _____ State _____ Zip _____ Country _____

Home Phone (____) _____ Home Fax (____) _____ Home E-mail _____

I wish to have my mail sent to (check one) Home Address Office Address

EDUCATION & TRAINING

Degrees	Name of University (Undergraduate)	City, State	From	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

	Name of Medical School	City, State	From	To
#1	_____	_____	_____	_____
#2	_____	_____	_____	_____

	Name of Training Program	Specialty	City, State	From	To
Internship	_____	_____	_____	_____	_____
Residency #1	_____	_____	_____	_____	_____
Residency #2	_____	_____	_____	_____	_____
Residency #3	_____	_____	_____	_____	_____
Colon & Rectal Fellowship (in approved training program)	_____	_____	_____	_____	_____
Additional Fellowship	_____	_____	_____	_____	_____
Certification (ABS)	_____	Cert. # _____	Date: _____	_____	_____

- Candidate Applicants: \$25 (to be submitted with application)
 have your program director provide a letter of recommendation and sign the application
 Submit Curriculum Vitae **if not certified by ABS or in an ACGME training program**

Signature of Sponsor: _____

Print Sponsor Name: _____

I hereby certify that: (A) I have read and will abide by the precepts of the Society's Bylaws; and (B) All information recorded on the application and any attached documents are accurate and support my qualifications for membership in ASCRS for which I now apply.

Date: _____ Signature of Applicant: _____

PAYMENT METHOD: Please submit the \$25 fee with your completed application to ASCRS Membership, 85 W. Algonquin Road, Suite 550, Arlington Heights, IL 60005 or FAX to 847/ 290-9203

My check payable to ASCRS is enclosed Please charge my credit card – V / MC / AM EXP

Card # _____ Signature _____ Exp Date _____