

The American Society of Colon and Rectal Surgeons  
**MEMBERSHIP REQUIREMENTS AND APPLICATION**

**Allied Health Professional / Affiliated Scientific Investigator**

**Application Deadline: March 15**



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ARLINGTON HEIGHTS, IL 60005  
PHONE: (847) 290-9184  
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## **MEMBERSHIP REQUIREMENTS**

To be eligible for membership/fellowship in the American Society of Colon & Rectal Surgeons, the applicant must meet the following requirements in the category applied:

### **APPLIED HEALTH PROFESSIONAL:**

*Annual Dues: \$50*

To qualify as an Allied Health Professional, an applicant:

- (a) must be a licensed Registered Nurse or Physician's Assistant with an interest in colon and rectal surgery. Each applicant must be sponsored by an active Member or Fellow of the Society.
- (b) member may attend and appear on scientific programs of the Society, and participate in discussions of scientific papers, but may not vote or hold office in the Society.

### **AFFILIATED SCIENTIFIC INVESTIGATOR:**

*Annual Dues: \$150*

To qualify as an Affiliated Scientific Investigator an applicant:

- (a) must hold an academic faculty appointment and have published articles related to diseases or conditions of the small bowel, colon, rectum or anus. Each applicant must be sponsored by an active Member or Fellow of the Society.
- (b) member may attend and appear on scientific programs of the Society, and participate in discussions of scientific papers, but may not vote or hold office in the Society.

ID #

For Office Use

# APPLICATION

## Allied Health Professional / Affiliated Scientific Investigator

The American Society of Colon and Rectal Surgeons  
85 W. Algonquin Rd., Suite 550 • Arlington Heights, IL 60005  
(847) 290-9184 • Fax (847) 290-9203 • E-mail: [ascrs@fascrs.org](mailto:ascrs@fascrs.org)

### PLEASE PRINT OR TYPE

I am applying for:  Allied Health Professional  Affiliated Scientific Investigator

Name \_\_\_\_\_  
(first) (middle) (last)  MD  PhD  LPN  PA  RN  
 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	City, State	From	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you been the subject of any disciplinary action by a local or state medical society or medical licensure body in the past 10 years?  Yes  No If yes, please provide an explanation in an accompanying letter.

Please list current medical society memberships (spell out):

1 \_\_\_\_\_ 2 \_\_\_\_\_

Allied Health and Affiliated Scientific Investigator Applicants: have your ASCRS Member/Fellow sponsor sign the application and provide a letter of recommendation.

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: \_\_\_\_\_

**PLEASE NOTE: An incomplete or unsigned application will not be processed.  
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