

**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](http://www.fascrs.org)

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## **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 While your home address and phone number will be retained on file, they will NOT be published, unless no office address is available.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 \_\_\_\_\_