



## AFFILIATED SCIENTIFIC INVESTIGATOR APPLICATION

Please type or print clearly. (An incomplete application will delay activation of membership.)

### APPLICANT INFORMATION

NAME, FIRST	MIDDLE	LAST	MD DEGREES	DO	PHD
OTHER DEGREES (SPECIFY)		DATE OF BIRTH	MALE FEMALE GENDER		
SPOUSE'S NAME, FIRST	MIDDLE	LAST			
PREFERRED MAILING/BILLING ADDRESS (Please choose only one)		PRIMARY OFFICE	SECONDARY OFFICE	HOME	

### PRIMARY OFFICE INFORMATION

COMPANY NAME			
ADDRESS 1			
ADDRESS 2			
ADDRESS 3			
CITY	STATE	ZIP	COUNTRY
OFFICE PHONE		OFFICE EMAIL	
OFFICE FAX		WEBSITE	

### SECONDARY OFFICE INFORMATION

COMPANY NAME			
ADDRESS 1			
ADDRESS 2			
ADDRESS 3			
CITY	STATE	ZIP	COUNTRY
OFFICE PHONE		OFFICE EMAIL	
OFFICE FAX		SECONDARY WEBSITE	

All ASCRS Communications will be sent to the Candidate Member's home address to ensure delivery so the following information is required.

**HOME ADDRESS INFORMATION**

ADDRESS 1

ADDRESS 2

ADDRESS 3

CITY STATE ZIP COUNTRY

HOME PHONE CELL PHONE HOME EMAIL

**COMMUNICATIONS**

Please review the communication options carefully. You will receive all ASCRS communications unless you specifically choose one or more of the following opt out preferences. If you have additional questions or concerns, please contact Membership Services for clarification.

- ASCRS occasionally provides members' addresses only to vendors who provide products and services to surgeons. If you prefer to opt out of these lists, please check this box.
ASCRS publishes your home address information in the member directory. If you prefer to opt out of listing your home information in the member directory, please check this box.
ASCRS publishes your primary office and secondary office information in the member directory. If you prefer to opt out of having your office information in the member directory, please check this box.
ASCRS publishes your spouse's name in the member directory. If you prefer to opt out of having your spouse's name in the member directory - both online and the printed copy - please check this box.

**EDUCATION AND TRAINING**

Please list all degrees that you have completed and those that you are pursuing.

DEGREE 1 UNIVERSITY/INSTITUTION FROM TO

DEGREE 2 UNIVERSITY/INSTITUTION FROM TO

**DISCIPLINARY ACTIONS**

1) HAVE YOU BEEN THE SUBJECT OF ANY DISCIPLINARY ACTION BY A LOCAL OR STATE MEDICAL SOCIETY OR MEDICAL LICENSURE BODY IN THE PAST TEN YEARS?

YES NO (If yes, please provide an explanation in an accompanying letter.)

**FOR CONSIDERATION**

APPLICANTS MUST HOLD AN ACADEMIC FACULTY APPOINTMENT AND HAVE PUBLISHED ARTICLES RELATED TO DISEASES OR CONDITIONS OF THE SMALL BOWEL, COLON, RECTUM OR ANUS. THE FOLLOWING ITEMS MUST BE SUBMITTED FOR THE ASCRS TO PROCESS YOUR AFFILIATED SCIENTIFIC INVESTIGATOR APPLICATION:

- \$150 Affiliated Scientific Investigator Fee.
Letter of recommendation from an Active Member or Fellow of the Society.
Submit a copy of your curriculum vitae.

**APPLICANT VERIFICATION**

I HEREBY CERTIFY THAT I HAVE READ AND WILL ABIDE BY THE PRECEPTS OF THE SOCIETY'S BYLAWS; AND THAT ALL INFORMATION RECORDED ON THE APPLICATION AND ANY ATTACHED DOCUMENTS IS ACCURATE AND SUPPORTS MY QUALIFICATIONS FOR MEMBERSHIP IN ASCRS.

Date Signature

