The American Society of
Colon and Rectal Surgeons

85 W. Algonquin Rd., Suite 550
Arlington Heights, IL 60005
Phone: (847) 290-9184
Fax (847) 427-9656
Website: www.fascrs.org

ALLIED HEALTH PROFESSIONAL APPLICATION

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

APPLICANT INFORMATION

MD DO PHD

NAME, FIRST MIDDLE LAST DEGREES

MALE FEMALE

OTHER DEGREES (SPECIFY) DATE OF BIRTH 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

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 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 BE A LICENSED REGISTERED NURSE OR PHYSICIAN'S ASSISTANT WITH AN INTEREST IN COLON AND RECTAL SURGERY. THE FOLLOWING ITEMS MUST BE SUBMITTED FOR THE ASCRS TO PROCESS YOUR ALLIED HEALTH PROFESSIONAL APPLICATION:

- $50 Allied Health Professional Fee.
- Letter of Recommendation from an Active Member or Fellow of the Society.

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 ALLIED HEALTH PROFESSIONAL MEMBERSHIP IN ASCRS.

Date ____ Signature ____

PAYMENT METHOD

PLEASE SUBMIT THE $50 FEE WITH YOUR COMPLETED APPLICATION AND LETTER OF RECOMMENDATION TO:

MAIL	FAX	PHONE	For questions please contact: ASCRS Membership Department membership@fascrs.org
ASCRS MEMBERSHIP DEPARTMENT 85 W. Algonquin Rd., Suite 550 Arlington Heights, IL 60005	(847) 427-9656	Amanda Wiff, Membership Manager (847) 725-2267	

PRINT AND RETURN THIS PAGE WITH YOUR PAYMENT

PAYMENT INFORMATION

Check *(Please make check payable to the American Society of Colon and Rectal Surgeons.)*

MasterCard VISA American Express

CREDIT CARD # SECURITY CODE EXP DATE

NAME ON CARD

SIGNATURE

FOR OFFICE USE

ASCRS ID #____________________