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

# CANDIDATE APPLICATION

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

## APPLICANT INFORMATION

NAME, FIRST | MIDDLE | LAST | ☐ MD ☐ DO ☐ PHD DEGREES

OTHER DEGREES (SPECIFY) | DATE OF BIRTH | ◯ MALE ◯ FEMALE GENDER

SPOUSE'S NAME, FIRST | MIDDLE | LAST

PREFERRED MAILING/BILLING ADDRESS (Please choose only one) ◯ UNIVERSITY/INSTITUTION ◯ HOME

## UNIVERSITY/INSTITUTION INFORMATION

UNIVERSITY/INSTITUTION NAME

ADDRESS 1

ADDRESS 2

ADDRESS 3

CITY | STATE | ZIP | COUNTRY

OFFICE PHONE | OFFICE EMAIL

OFFICE FAX | 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 member 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 university/institution 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

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

| | | | |
|---|---|---|---|
| DEGREE 1 | UNDERGRADUATE UNIVERSITY/INSTITUTION | FROM | TO |
| DEGREE 2 | UNDERGRADUATE UNIVERSITY/INSTITUTION | FROM | TO |
| DEGREE 3 | MEDICAL SCHOOL | FROM | TO |
| DEGREE 4 | MEDICAL SCHOOL | FROM | TO |

## TRAINING PROGRAMS

**Please list all that apply.**

| | | | |
|---|---|---|---|
| INTERNSHIP | SPECIALTY | FROM | TO |
| RESIDENCY 1 | SPECIALTY | FROM | TO |
| RESIDENCY 2 | SPECIALTY | FROM | TO |
| RESIDENCY 3 | SPECIALTY | FROM | TO |
| COLON & RECTAL FELLOWSHIP | SPECIALTY | FROM | TO |
| ADDITIONAL FELLOWSHIP | SPECIALTY | FROM | TO |

## FOR CONSIDERATION

THE FOLLOWING ITEMS MUST BE SUBMITTED FOR THE ASCRS TO PROCESS YOUR CANDIDATE APPLICATION.

- $25 Candidate Fee
- Letter of Recommendation from Program Director

## 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 CANDIDATE MEMBERSHIP IN ASCRS.

Date _____ Signature _____

## PAYMENT METHOD

PLEASE SUBMIT THE $25 APPLICATION FEE WITH YOUR COMPLETED APPLICATION AND LETTER OF RECOMMENDATION TO:

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

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 #_____