



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

MEMBERSHIP 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 GENDER		
FEMALE					
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 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 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.

ASCRS member office information is included in the Find a Surgeon search on the ASCRS website for patients and physicians unless a member requests to be excluded by checking 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

CERTIFICATIONS

ABS CERTIFICATION	CERTIFICATE #	DATE
ABS RECERTIFICATION	CERTIFICATE #	DATE
ABCRS CERTIFICATION	CERTIFICATE #	DATE
ABCRS RECERTIFICATION	CERTIFICATE #	DATE
OTHER CERTIFICATION	CERTIFICATE #	DATE

CURRENT ACADEMIC AFFILIATIONS

TITLE	UNIVERSITY/INSTITUTION
TITLE	UNIVERSITY/INSTITUTION

CURRENT HOSPITAL APPOINTMENTS

TITLE	HOSPITAL NAME
TITLE	HOSPITAL NAME
TITLE	HOSPITAL NAME

PRACTICE CHARACTERISTICS

- 1) ARE YOU ENGAGED IN PRIVATE PRACTICE? YES NO
- 2) I SPEND THE MAJORITY OF MY TIME IN: SOLO PRACTICE GROUP PRACTICE

PRIMARY PRACTICE ACTIVITY:

ACADEMIC
ADMINISTRATION
ARMED FORCES
GOVERNMENT
GROUP PRACTICE
GROUP PRACTICE MULTIPLE SPECIALTY
GROUP PRACTICE SINGLE SPECIALTY
HMO PRIVATE PRACTICE
HOSPITAL STAFF
PRIVATE PRACTICE
RESEARCH
RETIRED
SOLO PRACTICE

SECONDARY PRACTICE ACTIVITY:

ACADEMIC
ADMINISTRATION
ARMED FORCES
GOVERNMENT
GROUP PRACTICE
GROUP PRACTICE MULTIPLE SPECIALTY
GROUP PRACTICE SINGLE SPECIALTY
HMO PRIVATE PRACTICE
HOSPITAL STAFF
PRIVATE PRACTICE
RESEARCH
RETIRED
SOLO PRACTICE

PRACTICE CHARACTERISTICS

(CONTINUED)

3) MY PRACTICE OF COLON AND RECTAL SURGERY IS:

LIMITED TO COLON AND RECTAL SURGERY NUMBER OF YEARS LIMITED _____

NOT LIMITED TO COLON AND RECTAL SURGERY PERCENTAGE OF PRACTICE WHICH IS COLON & RECTAL SURGERY _____%

4) WHAT PERCENTAGE OF YOUR PRACTICE IS:

SURGICAL MANAGEMENT OF ANORECTAL DISEASE _____%

SURGICAL MANAGEMENT OF COLON DISEASE _____%

COLONOSCOPY _____%

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.)

2) HAVE YOU HAD YOUR HOSPITAL PRIVILEGES SUSPENDED, REVOKED OR MODIFIED **IN THE PAST FIVE YEARS?**

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

CURRENT MEMBERSHIP AFFILIATIONS

ACS MEMBER? YES NO IF YES, MEMBER SINCE _____

ACS FELLOW? YES NO IF YES, MEMBER SINCE _____

AMA? YES NO IF YES, MEMBER SINCE _____ AMA ID# _____

PLEASE LIST CURRENT MEDICAL SOCIETY MEMBERSHIPS (SPELL OUT):

1) _____ 2) _____

3) _____ 4) _____

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 _____

QUALIFICATIONS

TO BE ELIGIBLE FOR MEMBERSHIP/FELLOWSHIP IN THE AMERICAN SOCIETY OF COLON & RECTAL SURGEONS, THE APPLICANT MUST MEET THE FOLLOWING REQUIREMENTS: **ANNUAL DUES \$325** **APPLICATION FEE \$100**

TO QUALIFY AS A MEMBER, AN APPLICANT SHALL:

1. Be a graduate from a medical school accredited by the Liaison Committee on Medical Education (LCME), an accredited school of osteopathy or an accredited foreign medical institution;
2. Be fully trained in general surgery as evidenced by (a) certification by the American Board of Surgery; (b) satisfactory completion of an accredited general surgery residency as evidenced by a letter of recommendation from the director of the training program; or (c) completion of training in an accredited foreign medical institution which qualifies the applicant to practice general surgery in his or her country of residence.
3. International applicants must provide a letter from their Professor stating they have completed general surgery training and are practicing surgery with an interest in colon and rectal surgery;
4. Be fully licensed to practice medicine in a state of competent jurisdiction;
5. Be of high moral, ethical, and professional standing.

FOR CONSIDERATION

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

- SUBMIT A COPY OF ONE OF THE FOLLOWING:
 - American Board of Surgery Certificate
 - Copy of your letter from the American Board of Surgery
 - Letter of Recommendation from the director of your training program stating satisfactory completion of the accredited general surgery residency
 - Letter from the foreign medical institution Professor stating you have completed general surgery training and are practicing surgery with an interest in colon and rectal surgery
- SUBMIT A COPY OF YOUR CURRICULUM VITAE
- SUBMIT A COPY OF YOUR CURRENT MEDICAL LICENSE

PAYMENT METHOD

PLEASE SUBMIT THE \$100 APPLICATION FEE AND ALL REQUIRED DOCUMENTATION 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 # _____