

## TYPE OF PHYSICIAN MEMBERSHIP

- Active:** ABMS Board certified MD, DO or PhD residing in North America  
 **Associate:** Board-eligible MD, DO or PhD candidate residing in North America  
 **Corresponding:** Open to any health care professional residing outside North America who is involved in spine care

## PERSONAL INFORMATION

Name (including degrees) \_\_\_\_\_

Institution \_\_\_\_\_

E-mail Address \_\_\_\_\_

Address \_\_\_\_\_

Preferred Billing/Mailing Address:  Institution  Home

City/State/Zip/Country \_\_\_\_\_

Citizenship:  United States  Canada  Mexico

Office Phone \_\_\_\_\_

Other \_\_\_\_\_

Office Fax \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

Sex:  Male  Female

City/State/Zip/Country \_\_\_\_\_

AMA Member?  Yes  No

Home Phone \_\_\_\_\_

AMA Member ID# \_\_\_\_\_

Home Fax \_\_\_\_\_

## EDUCATION/CERTIFICATION/LICENSURE

**College/University** \_\_\_\_\_ City/State \_\_\_\_\_ Graduation Year \_\_\_\_\_

Degree \_\_\_\_\_ Major(s) \_\_\_\_\_

**Postgraduate** \_\_\_\_\_ City/State \_\_\_\_\_ Graduation Year \_\_\_\_\_

Degree \_\_\_\_\_ Major(s) \_\_\_\_\_

**Internship** \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Specialty(ies) \_\_\_\_\_

**Residency** \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Specialty(ies) \_\_\_\_\_

**Fellowship** \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Specialty(ies) \_\_\_\_\_

**Other Special Education** \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Specialty(ies) \_\_\_\_\_

**Board Certified?**  Yes Date \_\_\_\_\_  No If No, Board Eligible?  Yes  No

Name of Board (please attach certificate) \_\_\_\_\_

**Medical License?**  Yes Type \_\_\_\_\_  No

State/Province \_\_\_\_\_ License No. \_\_\_\_\_ Date Issued \_\_\_\_\_

State/Province \_\_\_\_\_ License No. \_\_\_\_\_ Date Issued \_\_\_\_\_

## CURRENT PRACTICE

How much of your practice is spine-related?  Less than 25%  25-50%  50-75%  75-100%

Indicate the percent of your professional activities spent in: \_\_\_\_\_% Clinical Practice \_\_\_\_\_% Academics \_\_\_\_\_% Research

If in Clinical Practice, please indicate type:

Solo  Single Specialty Group  Multispecialty Group  Private Hospital  VA/Government Hospital  Teaching Hospital

Indicate your areas of specialization: (1 for primary, 2 for secondary, 3 for tertiary)

____Anatomic/Clinical Pathology	____General/Family Practice	____Orthopedic Surgery	____Rheumatology
____Anesthesiology	____Geriatric Medicine	____Pain Management/Medicine	____Sports Medicine
____Basic/Applied Research	____Musculoskeletal Oncology	____Psychiatry/Psychology	____Trauma Surgery
____Chiropractic Care	____Neurology	____PM&R/Physiatry	____Other: _____
____Critical Care	____Neuropathology	____Radiology	
____Emergency Medicine	____Neurosurgery	____Physical/Occupational Therapy	

## DISCLOSURE

If licensed, has your license to practice in any jurisdiction ever been limited, suspended or revoked?  Yes  No

(If Yes, please attach an explanation on a separate sheet.)

Has any hospital ever denied your request for any type of medical/surgical privileges? Has any hospital reduced, restricted, suspended, terminated or requested you resign all or any position of your medical/surgical staff privileges, or is any attempt to do so now in progress?  Yes  No (If Yes, please an explanation on a separate sheet.)

Should this information change at any time during your membership, it is your responsibility to notify the NASS Membership Department.

## REFERENCES

Please list two colleagues familiar with your work, preferably NASS members, and identify their specialties. If you do not know any NASS members, list two colleagues. Limit one per partner/practice. **OPTIONAL:** Have each submit a recommendation letter to NASS.

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City/State/Province \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City/State/Province \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

## CURRICULUM VITAE

Please attach a current Curriculum Vitae.

## WHY DO YOU WISH TO BECOME A MEMBER OF THE NORTH AMERICAN SPINE SOCIETY?

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## NONREFUNDABLE APPLICATION FEE: \$50

A credit card authorization or check made payable to the North American Spine Society in US Dollars drawn on a US bank must accompany this application form.  Check enclosed Please charge my:  Visa  MasterCard  AmEx

Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name on Card \_\_\_\_\_ Signature \_\_\_\_\_

## AUTHORIZATION

By applying for membership in the North American Spine Society, I agree to be bound by the Bylaws and the Rules and Regulations of the North American Spine Society.

I am willing to appear for an interview if necessary. I hereby authorize the North American Spine Society and its representatives to consult with individuals or institutions with which I have been associated and to obtain information bearing on my professional competence, character and ethical qualifications.

I hereby release from liability all representatives of the North American Spine Society and their representatives for their acts performed in good faith and without malice in connection with evaluating my application, my credentials and my qualifications. I also release from any liability all individuals and organizations who provide information about me to the North American Spine Society in good faith and without malice, and I thereby consent to the release of such information.

Signature \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Please mail or fax your completed form with all attached documents to:

Membership Department  
North American Spine Society  
7075 Veterans Blvd.  
Burr Ridge, IL 60527

Fax: (630) 230-3700