



7075 Veterans Blvd., Burr Ridge, IL 60527
t (866) 960-6277 p (630) 230-3600 f (630) 230-3700
www.spine.org

MEMBERSHIP APPLICATION

1. TYPE OF PHYSICIAN MEMBERSHIP *(Allied health professionals use Affiliate form)*

Check one:

Active (ABMS Board certified MD, DO or PhD residing in North America)

Note: All applicants for active membership must devote at least 50% of their professional activities to treating patients with spine disorders or conducting spine-related research.

Associate (Board-eligible MD, DO or PhD candidate residing in North America)

2. PERSONAL INFORMATION *(please type or print)*

Name (including degrees) _____

Date of Birth _____ Sex Male Female

Institution _____

Address _____

City _____ State/Province _____ Postal Code _____

Country _____ E-mail Address _____

Office Phone _____ Office Fax _____

Home Address _____

City _____ State/Province _____

Postal Code _____ Country _____

Home Phone _____ Home Fax _____

Preferred Billing/Mailing Address: Home Office

Spouse's Name *(if applicable)* _____

Citizenship United States Canada Mexico Other _____

AMA Member? Yes No AMA Member ID# _____

Photo (optional—*please attach a recent passport-size photo to the upper right-hand corner of this page*)

All information must be filled in completely before the application can be processed.

3. EDUCATION/CERTIFICATION/LICENSURE

- » **College/University** _____ City/State _____
Graduation Year _____ Degree _____ Major(s) _____
- » **Postgraduate** _____ City/State _____
Graduation Year _____ Degree _____ Major(s) _____
- » **Internship** _____ Length of Training _____ Start Date _____ End Date _____
Specialty(ies) _____
- » **Residency** _____ Length of Training _____ Start Date _____ End Date _____
Specialty(ies) _____
- » **Fellowship** _____ Length of Training _____ Start Date _____ End Date _____
Specialty(ies) _____
- » **Other Special Education** _____ Specialty(ies) _____
Length of Training _____ Start Date _____ End Date _____
- » **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 _____

4. CURRENT PRACTICE

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 | ___Geriatric Medicine | ___Psychiatry/Psychology |
| ___Anesthesiology | ___Musculoskeletal Oncology | ___PM&R/Physiatry |
| ___Basic/Applied Research | ___Neurology | ___Radiology |
| ___Chiropractic Care | ___Neuropathology | ___Physical/Occupational Therapy |
| ___Critical Care | ___Neurosurgery | ___Rheumatology |
| ___Emergency Medicine | ___Orthopedic Surgery | ___Sports Medicine |
| ___General/Family Practice | ___Pain Management/Medicine | ___Trauma Surgery |

All information must be filled in completely before the application can be processed.

Please list all current hospital appointments: _____

Please list all current academic appointments: _____

Please list all current professional society memberships:

City/County _____

State _____

National _____

International _____

Specialty _____

5. 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 attach an explanation on a separate sheet.)

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

6. REFERENCES

Please list two colleagues who are Active NASS Members and are familiar with your work, and identify their specialties. Have each of them submit a letter of recommendation to NASS. If you don't know two Active NASS Members, please ask two colleagues to submit letters on your behalf. **Please limit one letter per partner/practice.**

Name _____ Specialty _____

City, State/Province _____

Name _____ Specialty _____

City, State/Province _____

7. PUBLICATIONS

Please attach a list of your published research papers, editorials, chapters, etc. —including date and publication — and works in progress. If none, please indicate here: None

8. CURRICULUM VITAE

Please attach a current Curriculum Vitae.

9. NONREFUNDABLE APPLICATION FEE: \$50.00

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 Number _____ Exp. Date _____

Name on Card _____ Signature _____

Continued on the next page

All information must be filled in completely before the application can be processed.

10. Why do you wish to become a member of the North American Spine Society?

AUTHORIZATION

In making this application 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 return your completed application form with all attached documents and check to:
Membership Department, North American Spine Society, 7075 Veterans Blvd., Burr Ridge, IL 60527 USA*

Please do not submit membership dues now. You will be billed after acceptance.

FOR OFFICE USE ONLY

Date Rcd _____ Chk No _____ Source _____