



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

**AFFILIATE MEMBERSHIP APPLICATION**

**1. AFFILIATE MEMBERSHIP: For Allied Health Professionals Only.**

- Check one:  Chiropractor       Physician Assistant       Nurse Practitioner  
 Physical Therapist       Nurse       Surgical Technician  
 Researcher       Practice Administrator       Coding Professional  
 Other \_\_\_\_\_

**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 \_\_\_\_\_

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) \_\_\_\_\_
- » Other Special Education \_\_\_\_\_ Specialty(ies) \_\_\_\_\_  
Length of Training \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_
- » Licensed?  Yes Type \_\_\_\_\_  No  
State/Province \_\_\_\_\_ License No. \_\_\_\_\_ Date Issued \_\_\_\_\_  
State/Province \_\_\_\_\_ License No. \_\_\_\_\_ Date Issued \_\_\_\_\_

### 4. CURRENT PROFESSIONAL ACTIVITIES

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                |

Please list any current academic appointments:

\_\_\_\_\_  
\_\_\_\_\_

Please list all current professional society memberships:

City/County \_\_\_\_\_  
State \_\_\_\_\_  
National \_\_\_\_\_  
International \_\_\_\_\_  
Specialty \_\_\_\_\_

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**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 \_\_\_\_\_

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

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

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### **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 \_\_\_\_\_