

IN-TRAINING MEMBERSHIP

For Residents and Fellows only. Check one:

Resident Fellow

Location of Training Program _____ Completion Date _____

Program Director (please print) _____ Director's Signature _____

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 _____

Home Phone _____

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) _____

Licensed? Yes Type _____ No

State/Province _____ License No. _____ Date Issued _____

State/Province _____ License No. _____ Date Issued _____

SPECIALTY

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

<input type="checkbox"/> Anatomic/Clinical Pathology	<input type="checkbox"/> General/Family Practice	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Geriatric Medicine	<input type="checkbox"/> Pain Management/Medicine	<input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Basic/Applied Research	<input type="checkbox"/> Musculoskeletal Oncology	<input type="checkbox"/> Psychiatry/Psychology	<input type="checkbox"/> Trauma Surgery
<input type="checkbox"/> Chiropractic Care	<input type="checkbox"/> Neurology	<input type="checkbox"/> PM&R/Physiatry	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Critical Care	<input type="checkbox"/> Neuropathology	<input type="checkbox"/> Radiology	_____
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Physical/Occupational Therapy	_____

CURRICULUM VITAE

Please attach a current Curriculum Vitae.

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