



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

IN-TRAINING MEMBERSHIP APPLICATION

1. IN-TRAINING MEMBERSHIP: *For Residents and Fellows only.*

Check one: Resident Fellow

Location of Training Program: _____
Completion Date: _____
Program Director (please print): _____
Program Director's Signature: _____

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) _____
- » **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*) _____
- » **Licensed?** Yes Type _____ No
State/Province _____ License No. _____ Date Issued _____
State/Province _____ License No. _____ Date Issued _____

4. CURRENT PRACTICE

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 all current professional society memberships:

City/County _____

State _____

National _____

International _____

Specialty _____

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

5. 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

6. CURRICULUM VITAE

Please attach a current Curriculum Vitae.

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 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 _____