

PRACTICE/HOSPITAL AFFILIATIONS

Practice Name: _____

Hospital (Primary) _____

City: _____

2. Hospital (Secondary) _____

City: _____

PROFESSIONAL AND SCIENTIFIC SOCIETIES

FLORIDA LICENSING BOARD

Florida License Number _____

Date Issued: _____

Licensing Board:

PAY BY CREDIT CARD

Amount Due: \$250.00

Name on Card: _____ Exp. Date _____

Visa Master Card American Express

Amount: _____ Card #: _____ ~~XXXXXXXXXXXXXXXXXXXX~~

Signature: _____

The endorsement, deposit or negotiation of an applicant's payment does not constitute admission into or acceptance of membership by the FVS. Payments received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a check refunding the amount submitted with the application.

REQUIRED ATTACHMENTS

1. Two letters of recommendation from Florida Vascular Society members. One letter must be from the physician that you Practice with.
2. Copy of Florida License
3. Submit photo as JPEG file to be used in membership directory. (Minimum file size 300px wide.)

I agree, if elected, to attend the meetings of the Society and to contribute by presentations and discussions.

Signature: _____

Typed Name: _____

SEND